Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner **Funeral** 1 □ M 2 💢 F Director 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland a or 28a-f show be notified at 1⊈Yes 2 No by Funeral Director 10g. Citizen of What Country? items 23a c Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 "natural", or 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. DUSEWI 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be CHICK UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BRENTALOOD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licens 21. Signature Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Other: 4 Surring Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 No 1 Inpatient 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D56691 30. Name and Horess of person who completed cause of death D. 12107 HERITAGE PK. CIR.

State Registrar

iand		Usua Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside City Lim	
Mary -fsh	to	Maryland N/A		Ba	altimo	ore						ty∑Yes 2□	
the	rec	10e. Street and Number				10f. Zi	p Code	_		10g. Citize	en of What Co	ountry?	
3a or	E D	2214 W. Saratog	a Stree	t			2122	23		USA			
re, Maryland 2/215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. tien 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1	?		Vas Dece Yes, spe □Yes		spanic Drigin? (Sp n, Mexican, Puerto Specify:	ecify Yes or Rican, etc.)		4. Race - Ame Black, Whit Specify:		
10 Pour 10 6 6	edt				16a. Deced	ent's Usi	ual Occup	ation		16b. Kin	d of Business	/Industry	
d 21215-0036 diled within 72 hours aff Hygiene. The Watural", or ent, the Medical Exprin	omplet	15. Decedent's Edu (Specify only highest grad	e completed) College (1-4or	5+)	(Give life. L Home	kind of we DO NOT I make	ork done d use retired ⊇ °	ation during most of work l)	ing	Own	Home		
laryland 2/21	Be Co	8th grade 17. Father's Name (First, Middle, Last) James Wilmore						18. Mother's Nam Melvin	e (First, Midd a Dix	dle, Maiden S ON	Surname)		
Maryland 2 Maryland 2 Ma should be filed wi th and Mental Hygier Tris marked other the triaumatic event, the	12	19a. Informant's Name/Relationship (7) James E. Lowry/			19b. Mailin	g Addres	SS (Street Onin	and Number or Ru gton Av	ral Route Nui enue	Number, City or Town, State, Zip Code) C Gwynn Oak, Maryla 212			
0 0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	20b. P	lace of Dispo emetery, cren	sition (Na natory or Bra	ame of other place nch	church ⁹	Čem.	20c. Loc York	ation - City or	Town, State of Carol	
Baltime permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens	Day.	is	5 2	. Name a	and Addre	ss of Facility terstow	atman	-Harr Balti	ris Fu	neralHon MD 21215	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause	d the death	n. Do not ent	er the mo	ode of dyir	ıg, such as cardiad	or respirator			Approximate Interval Between	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ero	sulev	oti	20	indipolas	sula.	r Dis	295 l	Onset and Death	
Examiner and and I-tunesit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s consequence	valuence of):	Va	elli	av Di tus	sease			Years Years	
1s, P.O. Box 68760, res that the death certificate be e. signed by the attending physician be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3		pregnand	y		_	3d. Date of d Month	elivery Day Year	
, P., that that the by detact		Part II. Other significant conditions co	ontributing to death	but not res	ulting in the u	nderlying	cause giv	ren in Part I.	23e. D	id tobacco u	se contribute	to the cause of death	
rds quires in sigr	d by								1	□Yes 2[□ No 3□	Probably 4 Unkn	
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Vita rsician: s certifica	Be (25. Was case referred to medical examiner?						26. Place of Dea	ath (Check or	nly one)			
of V nysic nis ce	ျှ	1⊿Yes 2□No			ER/Outpatie		DOA	ner: 4 Nursing H				pecify)	
ion of nding Physuth. : Arer this		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, E	njury Day, Year)	28b. Time o Injury	f M	28c. Inju Wo 1 🗆	ryat rk?]Yes 2 □No	28d. Descr	ibe how injur	y occurred		
Division of Vits To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifit completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streen City or Town,										Rural Route Number,	
Divi	edical C	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the besininer: On the basis	of examina	owledge, deat ation and/or in	h occurre vestigati	ed at the t	ime, date and plac opinion, death occ	e, and due to urred at the ti	the cause(s me, date and) and manner I place, and d	as stated. lue to the cause(s)	
o the outhing the complex comp	Me	29b. Signature and title of certifier				2	29c. Licen	se number		29d. Da	te signed (Mo	nth, Day, Year)	
		> mularan	Jim)) (16418		Jav	nuary	1 29,20	
51		30. Name and address of person who			m 23a) (Type,		A	ve Bal	time	DVP ,	MDS	1229.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Day Year 27 2010 January 4c. County of Death 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) S.Carolina Jan.13,1917 10d, Inside City Limits ty∑Yes 2 No zen of What Country? USA 14. Race - American Indian, Black, White, etc. Black nd of Business/Industry n Home Surname) n Oak, Maryland cation - City or Town, State k, South Carolina ris FuneralHome imore, MD 21215 Approximate Interval Between Onset and Death CCIVS 23d. Date of delivery Year Month use contribute to the cause of death? □ No 3□ Probably 4□ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

DHMH 17 Rev 1/2001

State Registrar

For State Registrar

5. Social Security Number

248-50-0041

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Carrie B. Lowry

-acnes

4a. Facility Name (If not institution, give street and number)

6. Sex

1□ M 25 F

Certificate of Death

Months Days

7. Age (In yrs. last birthday)

93

Yrs.

4b. City, Town, or Location of Death

Baltimore

If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min.

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058965 Khanva 910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) iberty M.B Kandalls SAIMA KHAWA JA 32. Registrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL**

29a. Certifier

one)

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per ME g900 2/4 10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death of Death Physician/ Charles Edward Lamb Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1XXM 2 | F 2/7/1917 217-01-3531 Months Hours Director 92 Baltimore, Maryland Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 21212 404 Old Trail of America Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1XXYes 2 □ No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin. 2 1 Never Married 2 Married white 1 Yes XX No Specify. altimore, Maryland 21215-003 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sports Writer News American Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Lemke Joseph Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathryn P. Lamb/ wife 404 Old Trail Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 1 Burial XXCremation 3 Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final nysician disease or condition Medical resulting in death) Due to (or as a consequence of): daly Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami PROTED BY FORM the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be CERTIFY IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year led by the a detached for Yes 2 No 9 Unknown P.O. been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? performe certificate 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of injury 28c, Injury at work? Certificate: 28d. Describe how injury occurred After (Month, Day, Year) ☐ Natural 5 Pending within 24 hours after death.

To the Funeral Director; Aft completed filled in by the fur 3: 00 P 1 Yes FALL Accident Investigation 01 26 2010 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10755 Falls Road determined building, etc. (Specify) ... uthemile OFFICE Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of cep 29c. License number 29d. Date signed (Month. Day, Year) MI 28, 2010 January D0063129 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a Beliedere Ave Bothinge MUZINOS SINA HOSPITAL OF BATTMORE, 2401 32. Registrar's Signature State ESEAR Registrar

			Please Type or Print in Black I				
			1 _ State	partment of Health and Mertificate of Death		0010	02505
			Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Beatif	2. Date of Deat		3. Time of Death
	Physicia /Medic		Margaret Amelia Larmore		Month Jan.	Day Year 28, 2010	4:45 P. M
- W	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
AR.	Funeral	-	12 Jordan Mill Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	White Hall y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltimore 9. Birtl	pplace (State or Foreign
	Director		217–26–2628 1 □ M 2 M F 81 Yrs.	Months Days Hours Min.	Sept.27		timore,MD.
	/land low		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	e Man 3a-f sh tified	ctor	Maryland Baltimore County White				1 □Yes 2□No
	thin 72 hours after death with the Maryland a.e. "natural", or items 23a or 28a-f show Mackeal Examiner must be notified at	Funeral Directo	10e. Street and Number 12 Jordan Mill Court	10f. Zip Code 21161	1	Og. Citizen of What Col United Sta	•
	death ms 23	nera		B. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
30	hours after tural", or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2▼ No	1 ☐Yes 2 ②No Specify:	nican, etc.)	Black, White Specify:	White
5-0036	hours		3 ☐ Widowed 4 ☑ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	cedent's Usual Occupation		16b. Kind of Business/l	
212 212	within 72 iene. than "nai	Completed	(Specify only highest grade completed) (Gir	ve kind of work done during most of working to NOT use retired)	ng		
2	22 (3)		12 n/a C	afeteria Worker 18. Mother's Name	(First. Middle. I	High Sch	1001
/land	id be filed lental Hys ked othe ic event,	To Be	William Ziegler	Viola Ram		,	
Mary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			iling Address <i>(Street and Number or Rura</i> Jordan Mill Court		r, City or Town, State, 2 Hall, Mary	
	1 and Health tem 27 other t		THE TROOPER THE PROPERTY OF TH	position (Name of	ate	20c. Location - City or	
E E	nit. Pages artment of ortant: If ite Injury or o		1 Laburiai 2 Li Cremation 3 Li Hemovai from State	ı rex	0.02,	Woodlawn,	Maryland
Baitimore,	permit. Departr Importa any Inju		10111 - 5 97112 16	22. Name <i>a</i> nd Address of Facility Peaceful Alternativ	es Fune:	ral&Cremati	-
	20360		23a. Part (Enter the disease, or complications that caused the death. Do not e	2325 York Road Ti	monium.	Maryland	21093 Approximate
4,	Physician		shock or Meart failura/List only one cause on each line. Immediate Cause (Final disease or condition	no ollaras	Cal	XON	Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
	LXaiiiiiei	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				-
۹.	e executed ian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Do.	be exe cian ar curial-ti	_	resulting in death) Last Due to (or as a consequence of):				
9/89	death certificate be attending physicia for use as the bur	edica	d				
X R R	th cert tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of del	ivery Day Year
5	requires that the death certificate be seen signed by the attending physicia hould be detached for use as the bur	by Physician/Medica	in the past 12 months? 1 Yes 2 Ido 9 Unknown	5 ☐ Other (specify)		World	Day Tour
ν., σ.	w requires that the de sbeen signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ora	require een sig				1 🗆 Y		robably 4 Unknown
ပ္မ	aw 2 sl	Completed			24a. Was a autop: perfor	sy prior to death?	topsy findings available completion of cause of
_	siclan: The law certificate has b irector, page 2 s	a	25. Was case referred to medical	26. Place of Death			2 🗆 No
o	Physiclan: this certific ral director,	To B	examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpat	ient 3 ☐ DOA Other: 4 ☐ Nursing Ho		ence 6 Other (Spe	cify)
	ding P h. After t funera	ion:	27. Manner of Death 1		28d. Describe h	ow injury occurred	
DIVISION	Attending or death. ector: After by the fune	Certification: To	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (S City or Tow	Street and Number or Re	ural Route Number,
בֿ	oital or urs afte eral Dir illed in						o stated
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	rain occurred at the time, date and place, rinvestigation, in my opinion, death occur	red at the time,	date and place, and due	e to the cause(s)
1	To the within To the comp	Me	29b. Signature and title of certifier Councilly M	D 29c. License number D 4-14-06		Date signed (Mont	h, Day, Year) 7th-2010
	6		30. Name and address of person who completed cause of death (Item 23a) (Typ	GPrint) IORTH CHA	RLES	STREE	204
	Sta		31. Date filed (Month, Day, Year) 32. Segistrar's Signature			1 4 1 100	
DHI	Registr		LU V & CUIU JOHNES J. J.	Berke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:54AM EVA LEVIN WAL Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Baltimore N/A Itumore If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M **X**(X) F 09/25/1923 86 Director 218-14-8069 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD N/A BALTIMORE 1 X Yes 2 □ No 5 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 239 4224 NADINE DRIVE 21215 USA ural", or items ? I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Bace - American Indian. Black, White, etc. à 1 X Never Married 2 Married 1 Yes If Yes, Give should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Callege (1-4 or 5+) and Mental Hygiene. QUALITY ASSURANCE EXAMINER SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL LEVIN TDA KAT7 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a ARLENE ROSENBERG/NIECE 218 CHURCH LANE, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of : of } : If it 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 01/31/2010 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Distand Peath Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-trar Due to (or resulting in death) Last led by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnati 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? ဂ္ Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner eath Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Pending work' 1 Tes 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifie 29c. License numbe

Registrar

DHMH 17 Rev 7/2009

State

Name and address of person who completed

31. Date filed (Month, Day, Year)

l D

Belvedere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ JÄNUARY LEVINE 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE GILCHRIST HOSPICE CARE TOWSON Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 💢 F Hours Min. 0172671926 MD 84 Yrs Director 220-18-9199 Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 X Yes 2 No BALTIMORE MD N/A 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral 6016 WOODCREST AVENUE 21209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify 3 Nidowed 4 □ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REPRESENTATIVE INSURANCE Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ COHEN BESSIE LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6016 WOODCREST AVENUE, BALTIMORE, NEAL S. LEVINE / MD 21209 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 2/1/2010 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lig Scott VI 18900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Panciente disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underl, in Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Dav in the past 12 months?
1 Yes 2 No Pregnant at time of death isigned by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 cate has t 1 Yes 2 No After this certificate funeral director, pag 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSOW 1 ☐ Yes 2 🕅 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 Yes 2 No Accident Investigation after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ร 24 hours a e Funeral I Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the I only one

State Registrar 29b. Signaty

TARON

31. Date filed (Month, Day, Year)

and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

icense number

29d. Date signed (Month, Day, Year)

M

30

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland				Mental Hyg	iene	
			State Registrar	Cer	tificate of D	eath	1	eg. No. 2	102508
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2, Date of Deat	y ^D I ^y , 2010	3. Time of Death 2:45 A M
	Medic		John P. Marshall						
	Examin	er	4a. Facility Name (if not institution, give street and number) 28751 Emanuel Street		4b. City, Town, or I			4c. County of Deat	h
	Funeval			st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia $497-32-9165$		Months Days	Hours Min.	Nov 15	1932 Inc	untry) iiana
	- MO	l. 1	Usual Residence of Decedent						
	yland -f sho	cto		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕎 No
	r 28a notifi	·=	Maryland Talbot 10e. Street and Number	E	aston 10f. Zip Code		Τ.	10g. Citizen of What Co	
	/ith th		28751 Emanuel Street		2160	1		USA	unity.
	ems r mus	Funeral	11 Marital Status 12, Was Decedent Ever in U.S	i. 13. \	Vas Decedent of His	panic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian,
ဖွ	or it	by F	Armed Forces? 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No		f Yes, specify Cubar I □ Yes 2 🏿 No		Rican, etc.)	Black, White	e, etc. nite
003	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than dical Examiner must be notified at	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.						
5-(72 hor "nat edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done do	ition uring most of work	king	16b. Kind of Business	Industry
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d 2	filed w al Hygi d other	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, N		
_l an	l be fi fental rked tic ev	잍	W.J. Marshall			Flore	nce Newk	irk	
ary	should n and Me 7 is mar raumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street a	nd Number or Rui	ral Route Number,	City or Town, State, Zip	Code)
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	IJ	Mary Jo Marshall, Wife			Street	Easton,	Maryland 2	
ore	e 1a t of H If ite or oth		1 Burial 2 X Cremation 3 Bemoval from State	emetery, crer	sition (Name of matory or other place		Date	20c. Location - City or	
ţim	t. Pag tmen rtant:		4 ☐ Donation 5 ☐ Other (Specify) Met		ematory I			Baltimore,	
Bal	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee Thomas Gregor	22	Name and Address remation 299 Frede:	Society rick Roa	d ^{Of} Mary	land, Incore, Maryla	and 21228
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.						Approximate Interval Between
~ 7	Physician,		Immediate Cause (Final disease or condition	EAL	CANCE	R			Onset and Death UEAR
	Medical Examiner		resulting in death) Due to (or as a consequ	ience of):					•
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequ	uence of):					
β.	ted Insit	Examiner	Cause (Disease or iinjury	,				A.	
W	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Ä	that initiated events c. Due to (or as a consequence of the constant of the co	ience of):					
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	rtificar ing pl	Me	IF FEMALE:						
Box 687	or use	ian	23b. Was decedent pregnant in the past 12 months? in the past 12 months? 4 Pregnant at time of d	al death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year
ĕ.	that the death certifical ned by the attending pl	Physician/Me	1 Yes 2 No 4 Pregnant at time of d 9 Unknown 9 Unknown	leath 3L					
P.O.	that the	by Pr	Part II. Other significant conditions contributing to death but not resi	ulting in the (underlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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of Vital Records,	w require s been si 2 should l	Completed					24a. Was a		topsy findings available completion of cause of
Rec	The law cate has k	ĕ					perfor	med? death?	2 🗆 No
la I	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?			ace of Death (Che	ck only one)		
Ž	shysik this o	은	1 Hospital: 1 Inpatient 2	ER/Outpatie		4 ∐ Nursing F	T	ence 6 Other (Spec	ify)
n o	ding F h. After funer	ate	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	injury	work'	rat ? Yes 2 □ No	28d. Describe ho	ow injury occurred	
siol	Il or Attending Physician: The law requires after death. Director: After this certificate has been sign in by the funeral director, page 2 should be	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			103 2 110		treet and Number or Ru	ral Route Number,
>	in the second		building, etc. (Specify				City or Town		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check conly one) 1 ☑ Certifying Physician: To the best of my knowl with the conly one) 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practioner: To the best of my	n and/or inves	stigation, in my opinio	n, death occurred	at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	North		29b. Signature and title of certifier		29c. License	number D3988		29d. Date signed (Mont.	h, Day, Year)
	10		30. Name and address of person who completed cause of death (Item David Smith 82211 Teal Drive			and 21601		-	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture	La del	110 21001	=		
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signat	p. 4	aver .				

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State of Maryland / Department of Health and Mental Hydiene 2010 02509

ari Miller			ment of Health and Mental Hy ficate of Death	ygierie Reg.		02303
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
ledical Exami		Carl Miller		January 21,	2010	0833 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	-	291 S. Ballou Court 5. Social Security Number 6. Sex 7. Age (In yrs. last		. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
Funeral Director		218-30-0128 1 XM 2 F 74	Months Days Hours Min.	_	Foreig	n ^{untr} Maryland
	ŀ	Usual Residence of Decedent		Tourie 4	, 1999	
' any	Ī	100.00	own or Location			10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	ŏ		Baltimore	100	. Citizen of What Cour	
Mary or 28a-	Director	10e. Street and Number	10f. Zip Code 21231	log	USA	,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	eral D	291 S. Ballou Court 11. Marital Status 12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian, Black,
leath v	Fune	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after o	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 195	5 1 Yes 2 No specify:	Table 1	Specify: whi	
hours natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti 		l6b. Kind of Business/I	naustry
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5-00 ed wit Hygien other	5	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Ma	iden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	B	George Miller	Mary 19b. Mailing Address (Street and Number or F	Mummert	Oit of Town State	Zio Codo)
Should Should Ar is may	입	19a. Informant's Name/Relationship (Type, Print) Pat Decker/daughter	11904 Woodberry Place			21087
MD and 2 sho lealth and tem 27 is traumati		20a. Method of Disposition 20b. Pla	ice of Disposition (Name of cemetery,		20c. Location - City or	Town, State
DOFE ages 1 nt of F other	4	1 Burial 2 Cremation 3 Removal from State	matory or other place)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once	ı	4 Donation 5 X Other Specify in State 21. Si nature Funeral Sevice Licensee ROTT S. Wake Injector	22. Name and Address of Facility State Anatomy Boar	rd 655 W.	Baltimore	Street
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Division tal or Attendii rs after death. aal Director: A	icat	2 Accident Investigation 28e. Place of Injury - At hom	ne, farm, street, factory, office building, etc.			ral Route Number, City
Divisospital or A hours after ineral Directly y filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ate)	
F 24		29a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner:On the basis of examination and	, death occurred at the time, date and place, and	d due to the cause	(s) and manner as stated	ted. ne cause(s)
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	29c. License number	at the time, date a	29d. Date signed (Mo	
	2	() M)	O.C.M.E.		January 27, 201	
		30. Name and address of person who completed cause of death (Item 2	3a)			
		Donna M. Vincenti, MD Assistant Medical Exami		/ID 21201		
	tate		1.70			
Regis		1-00 0 4 2010 700	ORIGINAL			
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			For State Registrar	State of IVI	aryland		irtment of H tificate of D		wentai ny	Reg. No. 7	010	02510	
	Physicia	n/	1. Decedent's Name (First, Middle,	ŕ					2. Date of De	Day	Year	3. Time of Death	
	Medic	al	Hubert B. Mulke	^				Landing of Doction	Januar		2010	5:30 a ^M	
	Examin	er	4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or Dayto:		1		unty of Death ward		
	Funeral		El Tern House 5. Social Security Number		e (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign	
	Director		245-14-7954	1 🔀 M 2 🗆 F	87	Yrs.	Months Days	Hours Min.	10/22	71922	Cour	place (State or Foreign ntry) NC	
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation			-		10d. Inside City Limits	
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	nwith	nera	8039 Old Monto					043			d Stat	es	
336	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	 11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced 	12. Was Decedent B Armed Forces? 1 M Yes 2 ☐ If Yes, Give Year or Dates.	Ever in U.S. No 1943 1946	5 - _	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🔀 No		pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecify: W		
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lary	should and N is ma raumat			Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z.									
	e 1 and 2 s t of Health If item 27 i		John Smith - br	other			Old Monte	gomery R					
Baltimore,	ge 1 a nt of H :: If ite or ot		20a. Method of Disposition 1 Description 2 Cremation	3 Removal from State	cen	netery, cren	sition (Name of natory or other place	:	Date		ion - City or T		
Itin	permit. Page 1:8 Department of H Important: If ite any injury or of		4 Donation 5 Other (S ₁ 21. Sign, up of Fundral Sevice		_		lge Cemete					MD ily F.H.Inc.	
Ba	permi Depar Impor any ir		Indu V	malo	747							, MD 21043	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o									Approximate Interval Between	
	Ph_sician/		Immediate Cause (Final disease or condition	· · · · · · · · · · · · · · · · · · ·		23	DISEA:	sE				Onset and Death	
-	Medical Examiner		resulting in death)	Due to (or as a	a conseque	nce of):							
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Q.	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events	c									
3 0	e exectian an	EX	resulting in death) Last	Due to (or as	a conseque	nce of):							
200	sate be executed physician and the burial-transit	edical	`	d									
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal of	death 3 🗆	Ectopic pregnancy Other (specify)	y		23d	I. Date of delive Month	very Day Year	
P.O.	nat the ed by 1 detach		Part II. Other significant conditio	ns contributing to death b	ut not result	ting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco use	contribute to t	the cause of death?	
s, F	ires the signer of the signer	d b	GLAUCOMA.	MACULA	R DO	EGEN	ERATIO	N)	1 🗆	Yes 2	No 3 🗆 Pro	obably 4 🗌 Unknown	
Division of Vital Records,	ie law requ e has beer ige 2 shou	Completed by	Hypertensi	ON, Imp.	AIREI	GLU	eose Me	TABOLIS	_ perf	psy ormed?	4b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of	
al B	ian: Th	Be	25. Was case referred to medical				26. Pla	ice of Death (Che		2 No	I LI Yes	2 A NO	
Vit	hysici his ce I direc	10 E	examiner? 1 Yes 2 No				t 3 DOA Othe	r: 4 Nursing H	lome 5 Resi	dence 6 🗷	Other (Specif	D LIVING	
οι	ling P. J. After t	ate:	27. Manner of Death 1 Natural 5 ☐ Pendin			8b. Time of injury	28c. Injury work		28d. Describe	how injury oc	curred		
sior	Attenc death ctor: /	Certificate:	2 Accident Investig 3 Suicide 6 Could	not be	ury - At hom	e, farm, stre		Yes 2 LINO	28f, Location (Street and No	umber or Rura	al Route Number	
) ivi	al or / s after il Dire		4 ∐ Homicide determi	building, etc					City or To				
	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2 Medical E	Physician: To the best of kaminer: On the basis of e Nurse Practioner: To the	xamination a	and/or invest	igation, in my opinio	n, death occurred	at the time, date	and place, and	d due to the ca	ause(s) and manner stated.	
	To the common co	_	29b. Signature and title of certifier	,			29c. License				igned (Month,		
0				um, luo				22832	-	02	1011	2010	
	2		30. Name and address of person v	who completed cause of d	eath (Item 2	3a) (Type, F	rint)	ELKRIN	ee. N	10 2	21075	5	
	Stat		31. Date filed (Month, Day, Year)	32 legistra	ar's Signatur	1 2	IN ST. E	0					
	Registra	ar	7FD A A	BOAR Process	4 4 6								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMONTARY 02:40A M Robert Gabriel Muth Medical 4c. County of Death Balt 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** timore wson Saint Joseph Medical Center 8. Date of Birth (Month, Day, Year) Aug 30, 1931 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 🛛 M 2 🗆 F Months Days Hours Maryland Director 216-28-1479 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Timonium Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21093 512 Limerick Circle, #401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" White 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Medica1 Nephrologist 12 Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H
Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) ဂ္ Egan Leo Muth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Cormer Court, unit 301, Timonium, MD 21093 Robert G. Muth, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/17°10 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland Bryan W. C. 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part I. Enter the disease, ir complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immedia e Cause (i inal disease y condition resulting in death Onset and Death Physician/ NEUMONIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Physician/Medical attending p as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown 1 ☐ Yes 2 ☐ Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYELODYSPLASTIC Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy Yes certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending I 1 Natural
2 Accident
3 Suicide
4 Homicide injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ichla MO () 2010 January DØØ41410 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON. MARYLAND 21204 DSLER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registra

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 05:170 Peggy L. Merrill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5 Omil 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) Funeral Days 1 M 2 F Director 217-30-8788 1934 Maryland 6 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 🛂 No Salisbury Maryland Wicomico 10f. Zip Code 21801 Street and Number 10g, Citizen of What Country? 1813 Emerson Avenue Baltimore, Marykand 21215-0036 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Specify: White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Heath Mary Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23950 Arunah Way, Hollywood, Maryland 20636 Cynthia Michael Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/4/2010 Owings Mills, Maryland 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 Falls Road, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death OBSTRUCTIVE PHIMON, ARY Physician/ HRONIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine il any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) the detached Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4/ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 6 Stother (Specify) HOSPICR 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PU BUP 31. Date filed (Month, Day, Year) State 32. Re Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:40 A M Jeo Rae MLASONI Medical DAM 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death BALL'MORE VAMEdiCAL 13ALtimore If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth (Month, Day, Year Mar. 9, 1 **Funeral** 9. Birthplace (State or Foreign 1 XM 2 ☐ F Months Days Hours Min. ^{Country)} New Jersev Director 1934 143-24-9601 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Maryland Harford 1 Yes 2 No Abingdon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 322 Overlea Place 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black White etc. Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 🗆 Widowed 4 🗆 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Airplane Mechanic U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert (nmn) Mason <u>Lillian (nmn) Wild</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Mason / Spouse 322 Overlea Place, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp: 4 Donation 5 Other (Specify) 2-2-10 Towson, Maryland ²² Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signatur of Funeral Service Licenses 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dualto (or as a consequence ory To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral is Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North Greene Street BALLimore, M. KUBIN e 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's_Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Virginia Vacirca Brown Musial 20^{Year} 12:25 am January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 4000 52nd Street Bladensburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) NY 1 □ M 2 → F Months Days Hours Min. (Month, Day, Year) 2/20/1917 208-22-7093 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Prince George's **Bladensburg** 1 Yes 2XX No 10e, Street and Number 5 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 4000 52nd Street 20710 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 🗶 No Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates th and Mental Hygiene.

77 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) Translator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincenzo Vacirca Clara Palunibo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 4000 52nd St. Bladensburg, MD 20710 Richard Brown, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/2/2010 Beltsville, MD 21. Signure Funeral Service Licenses 22. Name and Address of FacilityRapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transi and Due to (or as a consequence of) Physician/Medical certificate be 68760 use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Vital the funeral director. Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo ER/Outpatient 3 DOA 1 Inpatient 2 I After this of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 1 X Natural 5 Pending Division within 24 hours a er death. To the Funeral Director: A 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certified 29c, License number 29d. Date signed (Month, Day, Year) 1/29/2010 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Barry N.

31. Date filed (Month, Day, Year)

Rosenbaum,

FEB 0 2 2010 >

TRAINIR

32. Regist ar's Signature

MD 3720 Farragut Ave. Kensington, MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:00 Miller AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Center Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) Md **Funeral** 1 □ M 2 🔀 F Hours (Month, Day, Year) 69 Director 216.06.1085 39 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8016 Valley Manor Road 21117 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 \square Never Married 2 \square Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Waitress Hospitality Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked o ဂ Stephen Paul Fertitta Deborah Jean Miles permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic s 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Krystal Miller/daughter 323 East University Pkwy, Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Bel Air Memorial 1 Burial 2 Cremation 3 Removal from State 01.28.10 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA Signature of Funeral Service Licensee M01443 K 8717 Green Pastures Dr. Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Preumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AIDS Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Durito (or self-conerquence of) as been signed by the attending physician and 2 should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute renal failure 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsv performed? Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thomas J. Merble, M.D. P22133 Jan 23 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Green Street, Baltimore, MD 21201

DHMH 17 Rev 7/2009

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 2 1. Decedent's Name (First, Middle, Last) 7:42A M Month **Physician** 7 2010 ANUAR ANICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 - M 2 X F Yrs 232-82-6500 58 11/24/1951 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director MD HOWARD COLUMBIA 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 6024 CLOUDLAND COURT 21044 Funeral items 2 . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 7 is marked other than "natural", or iter traumatic event, the Medical Examiner 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) **EDUCATION &** Elementary/Secondary (0-12) College (1-4 or 5+) REHABILITATION SPEECH_LANGUAGE PATHOLOGIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evone. FRANK WILBURN EVELYN LOWE ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BERNAE MILLER / DAUGHTER 6024 CLOUDLAND COURT, COLUMBIA, MD 21044 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date etery crematory or other place)
CHAIM 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 1/31/2010 Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Unknown P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 No 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

State Registrar (check only one)

29b. Signature and title of certifier

Kenneth Isena 32. Registrar's Signature 31. Date filed (Month)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 1/2001

29c, License number

- 000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

University of MD 225 Greene ST Ballimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 01/26/1982 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Director 212-02-4823 Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 2.23 or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be refitted at once. MD Baltimore Baltimore **Funeral Director** 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21221 1649 Essextowne 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 10 <u>None</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susan Neighoff Lawerance Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1649 Essextowne, Baltimore, MD 21221 Susan Neighoff/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ardent Gremation Services 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licersee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Tracheostony dislogement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, obesity autopsy 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1-26-10 1 ☐ Yes 2 X No 2100 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a To the Funeral D

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Neighoff

Shawn

Physician

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dvr g900 2-2-10 vt. State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 Certificate of Death

2. Date of Death

Month

01

3. Time of Death

1633

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

10

Maryland

4c. County of Death

U.S.A.

14. Race - American Indian, Black, White, etc.

Specify: White

28

02/01/2010 Hanover, Maryland 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste. N, Hanover, MD 21076 Approximate Interval Between Onset and Death 12 days CENTRICATION APPROVED BY MEDICAL EXAMINER 23d. Date of delivery Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed 2 □No 2 **X**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred accidental Listodsenent of TracheosTomy afTer insertion
28f. Location (Street and Number or Rural Route Number,
City or Town, State) 22 S. Greene ST. Baltimore 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) R 150 747 28 2010 Baltimore MD 21201 5 T.

Registrar

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) --

Medical

S. Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 3,23d of Maryland of Deport 762 20 16 alth and Mental Hygiene? [] | [] 1 - For A State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Unknown M Day 2010 **Physician** BROWN FORD NESTOR JANUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ROSEDALE 1620 ROSEWICK AVENUE 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ kM 2 □ F Yrs. VÍRGINIA 236 28 1865 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location your ! 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examination ust by notified at 1 □Yes 2√∑No Director MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21237 USA 1620 ROSEWICK AVENUE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 📉 No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within nd Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) GENERAL CONSTRUCTION 12 CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be FRIEND CLARENCE NESTOR ETHEL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of Item 27 is Department of Health Important: If Item 27 any injury or other trong once. 1620 ROSEWICK AVE BALTIMORE, MD 21237

ce of Disposition (Name of Date 20c. Location - City or Town, State PHYLLIS J. NESTOR/WIFE altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 1/23/10 BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses CHESACO AVE BALTIMORE, MD 21237 1211 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Rospitateur dery Multitaituiul Encenhalanath **Physician** /Medical Due to (or as a consequence of): Examiner Yells Unantrolleil 1 al etes mellinus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Typertension burial-tran Due to (or as a consequence of): pecuo Division of Vital Records, P.O. Box 68760, physician Physician/Medical dronnel rement 4 the attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 X No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending after death. 1 ☐Yes 2 ☐No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one)

within 2

31. Date filed (/ State Registrar

29b. Signature and title of certifier

Rel Suite 1

M.D

and manner stated.

2angoli9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

29c. License number

DO065647

Paukville, MD

29d. Date signed (Month, Day, Year)

January 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 1/2001

State

6 V

30. Name and address of person who complete

31. Date filed (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a,b,perINF20a,b,perFH, G900, 2/26/2010, WS
State of Maryland / Department of Health and Mental Hygiene

		_1	For State Registrar		•	rtificate of D			Reg. No. 2	110	02520
	Physicia		1. Decedent's Name (First, Middle, Las Arthur Georg	•				2. Date of Dea Januar	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give		-	4b. City, Town, or	Location of Death	Januar	- 200	2010 ty of Death	5;40 P ^M _
			Casey House				ville	T==-		ntgome	
	Funeral Director		109-32-0203	2X	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day June 12	, 1944		lace (State or Foreign ry) eria
1	show	1 h	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo					10	Od. Inside City Limits
	Maryi 28a-f otifiec	Director	MD Montgo	mery		Silver Sp	ring		1 ☐ Yes 2 No		
1	ns 23a or	Funeral D	10e. Street and Number 15052 Shamrock R	idge Rd.			20906		10g. Citizen o Liber:		try?
9200	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dippartment of Health and Mental Hygiene. Important: If fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ሺ No		ecify Yes or No- Rican, etc.)		ace - America ack, White, e fy: Bla	tc.
1215-(thin 72 ho sne. than "nat he Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		(Give	dent's Usual Occupa kind of work done d OO NOT use retired) lectricia:	luring most of work	ing	16b. Kind of	Business Ind	
and 2	be filed wil antal Hygie ked other c event, th	a l	17. Father's Name (First, Middle, Last) Nanpu	Cee			18. Mother's Nam We11eh		Maiden Surnar		
Baltimore, Maryland 21215-0036	17 should be file alth and Mental H 27 is marked o rr traumatic eve		Paul A. Gladyu Paul Nanpu / Nep	rpe, Print) hew	8040	ng ridge Is ra S. Galdwe	ned Nymber or Para	Rout Nurte Salisbur	ge Gro	state, Zi M N 28144	1 ^{rde)} 55016
more,	Page 1 and nent of Hez ant: If item iry or othe	I I	20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	o. Place of Dispo		erv 2	0 0 2010	20c. Location	n - City or Tor	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licens	ween Moo3	282 2	Rapp Fune 933 Gist	ral and (Ave., Sil	Crematio Lver Spr	n Servi	ices D 20	910
	h, sician/ Medical Examiner	L	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Due to (or as a cons	Provas equence of):	er the mode of dying	g, such as cardiac o	^	est,		Approximate Interval Between Onset and Death
60 tra be evented	To the population therefore the control of the cont	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to for as a cons c. Due to (or as a cons d.						8	
. Box 68760	the attending posterior	ı≂ ı	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	etal death 3	☐ Ectopic pregnanc☐ Other (specify)	y			ate of delive	ery Day Year
s, P.O.	signed by	ρ	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause giv	en in Part I.	_			e cause of death?
Division of Vital Records,	ate has beer page 2 shou	Completed						24a. Was a autop perfo	sy med?	o. Were autop prior to cor death? 1 \(\sum \) Yes	osy findings avallable inpletion of cause of
ta	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	_	Othe	ace of Death (Chec				1/2
of V	er this eral dir	و: 2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 28a. Date of injury	28b. Time o	nt 3 □ DQA f 28c. Injury	4 ∐ Nursing Ho / at	ome 5 Resid			Hospice IRU
uo	er units eath. or Afte	ficat	1 Matural 5 Pending 2 Accident Investigation) injury	M 1 □	? Yes 2 \(\subseteq No				
ivisi	fter d in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		reet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
	nospital 24 hours Funeral eted filled	Medical	(Check 2 Medical Exam	sician: To the best of my kr ner: On the basis of examina se Practioner: To the best of	ation and/or inves	stigation, in my opinic	on, death occurred a	t the time, date a	nd place, and c	lue to the cau	use(s) and manner stated.
T.	vithin Vithin Comp	2	only one) 3 L. Certifying Nurse 29b. Signature and title of certifier	se Fractioner. To the best of	Tilly Kilowieage,	29c. License			29d. Date sign	ed (Month, L	Day, Year)
						MD33	3755 		Janu	ary 30	2010
			30. Name and address of person who of Joseph Bindu M.D.				ockville	MD 20	1852		
	Sta		31. Date filed (Month, Day, Year)	32. Regist ar's Si							
	Registra	ar	FEB 07	2 2010 Dener	N B.	parker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD & #11 per Fh g900 2/3/10 TT

State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 10 2010 Month **Physician** 0132M January Randolph Owens /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BAYWIEW MEDICAL BALTIMORE HOPKINS SMHOL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10-15-1931 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F MD Director 216-28-0621 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show in than "natural", or items 23a or 28a-f show 1X Yes 2 No MD Director BALTIMORE **EDGEMERE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2532 **SYCAMORE** AVE. Funeral 21219 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married Married 1 □Yes 2 □ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within the and Mental Hygiene. 7 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) **SWITCHMAN** RAILROAD or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER မ OWENS MATTIE YOUNGBLOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If item 27 is n any Injury or with 2409 LODGE FARM ROAD EDGEMERE, MARYLAND 21219 GWENDOLYN BAYLOR/NIECE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-04-2010 CROWNSVILLE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Sina ure of Funeral Service Licensee a 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Multiorgan da Sequentially list conditions Due to or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit requires that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 □Yes 2 □No the is been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 □Yes 2 WNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 30 2010 RES-001

4+1

Baltimore, Maryland 21215-0036

Box 68760,

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of Vital Records,

Division

State Registrar

JEMILAT BADAMAS 4 31. Date filed (Month, Day, Year) 32. Regist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State c	of Maryla	and / Depa <i>Cer</i>	artmer <i>tificat</i>			d Menta		iene _{eg. No} 2	010	02522		
	Physicia	n/	1. Decedent's Name (First, I								Mon	of Deatl		Year	3. Time of Death		
	Medic	al	The 1ma 4a. Facility Name (if not insti		ine	Owen	s	4b City	Town or	Location of De		nuar		2010 unty of Deatl	10:40 A M		
	Examin	er	5921 Bonnie			iberj			1kri		9411			oward			
	Funeral	1	5. Social Security Number	6. S	ex □ M 2 🗓 K F		s. last birthday)	If Under	1 Year Days	If Under 24 H		of Birth	Year)	g. Birt Coa	hplace (State or Foreign untry) MD		
	Director		220-18-5886 Usual Residence of Decede		LI WI Z LAI	90	Yrs.				02-	th Day Year 919 Country MD					
	and show 1 at	ř	10a. State 10b. Co			10c.	City, Town or Lo	cation							10d. Inside City Limits		
	Maryl 28a-f otifie	irec		ward					ridg	e					1 🗌 Yes 2 ื No		
	th the 3a or t be n	la D	10e. Street and Number	X7.	T			10f. Zip		5		1	_	of What Co ed Sta	· ·		
	ath wi ems 2 r mus	Funeral Director	11. Marital Status	6921 Bonnie View Lane 21075 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig											Race - American Indian,		
õ	fter de , or it amine	<u>ک</u>	1 Never Married 2		Armed For 1 Tyes If Yes, Giv	2 X No				n, Mexican, Pu Specify:	ierto Rican, et	(C.)		Black, White			
3	ours at tural" al Exa	Completed		A Widowed 4 □ Divorced Year or Dates.											White		
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217	withir giene rer tha t, the		12		- College (1			Hom	emak					n Home	9		
and	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 25a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	, ,	r's Name (First, Middle, Last) Frank Lowery Ada James										name)			
Maryland 21215-0036	should to h and Me 7 is mark traumatic	Ī		nant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town											o Code)		
ž	C = 2 -		Larry H. Owe	ry H. Owens - Son 46900 Vermont Road, Unit 19, Punta C											a, FL 33982		
ore	e 1 and t of Heal if item 3 or other		20a. Method of Disposition 1 KPBurial 2 Crem											Location - City or Town, State			
Baltimore,	permit. Page Department o Important: If any injury or once.		4 Donation 5 0	ther (Speci	fy)	M∈											
Вa	Depa Impo any i	0.0		atule of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman F MMP., Inc., 7250 Wash. Blvd., Elk											ge, MD 21075		
ľ			23a. Part 1. Enter the disea shock, or heart failure	ise, or com List only o	plications that	caused the cach line.	leath. Do not ent	er the mod	e of dying	g, such as card	diac or respira	tory arre	est,		Approximate Interval Between		
	Pnysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)		a. /hylo	CARDIA	AL IN	FARC	TIDA	ر 					Onset and Death DAYS		
	Examiner		resulting in deathy	ſ	78.		sequence of):								DAYS		
		iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	J	D. —	(or se a con-											
	scuted and transit	Examiner	Cause (Disease or iinjury that initiated events	1	c. Due to	for as a cons	sequence of):										
	cate be executed physician and the burial-transit	edical E	resulting in death) Last	L	Due to	(0, 20 2 00)	304461100 017.										
3760	ficate g phys as the	Medi	IE FEMALE.		d												
Box 68	h certi tendin r use	an/I	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?			Birth 2	Fetal death 3	Ectopic		У			230	d. Date of de Month	livery Day Year		
Bo	e deat the at thed fo	Physician/M	1 Yes 2 X No		4 ∐ Preg 9 ☐ Unk	gnant at time nown	of death 5 L	☐ Other (s	oecify)					WOITE			
P.O.	that th	by Ph	Part II. Other significant co	onditions o	ontributing to	death but not	t resulting in the	underlying	cause giv	en in Part I.	236	e. Did tol	bacco use	contribute to	the cause of death?		
ds,	quires en sign	ted b	Hypen				-				- 1	1 🗆 Y	es 2 💢	No 3□P	robably 4 Unknown		
COL	law rec las be	Completed	VENOUS	IN	SUFFIC	CIENC	y of Lo	WER	Exi7	REMIT	IES 24	a. Was a	sy	24b. Were au prior to death?	topsy findings available completion of cause of		
Re	sician: The law r certificate has b irector, page 2 sl		05.14										2 No	1 \(\text{Ye}	s 2 No		
Ita	s certif	To Be	25. Was case referred to me examiner? 1 Yes 2 No	edicai	Hospital:	Innatient S	P □ ER/Outpatie	nt 3 🗆 D	Oth	er:	ng Home 5		ence 6	Other (Spec	cifv)		
of/	ng Phy ter this neral c		27. Manner of Death	Pending	28a. Date		28b. Time o		28c. Injury work	/ at			ow injury o				
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Division of Vital Records,	after of Direct			determined	28e. Place	e of Injury - A ling, etc. (Sp	At home, farm, str ecify)	reet, factor	y, office			ation (St or Town		iumber or Hu	ıral Route Number,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1. Cer	tifying Phy	rsician: To the	best of my ki	nowledge, death	occured a	t the time	, date and place	ce, and due to	the cau	se(s) and r	manner as st	ated. cause(s) and manner stated.		
	the H thin 24 the Fi	Me	only one) 3 🗆 Cer	tifying Nu	se Practioner	: To the best	of my knowledge,	death occi	irred at th	e time, date an	d place, and d	ue to the	cause(s) a	nd manner as	s stated. h, Day, Year)		
	5 № 6 8		29b. Signature and title of o	,	a, My	^				2832			O I	1291	7 2010		
	•		30. Name and address of p			ise of death i	(Item 23a) (Type,	Print)									
				ide.	M.D.		08 MAI	V ST	REE7	-, EL	CRINGE	, M	10 2	1075			
	Sta Registr		31. Date filed (Month, Day,		/	Registrar's Si	gnature :	20									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 02523 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2010 Physician/ 4:30P M Thomas Pidgeon, Sr. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Frederick Frederick Northampton Manor If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Month, Day, Year) 7/18/1936 1 🔀 M 2 🗆 F Months Pennsylvania 73 **Director** 175-26-2342 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 🛛 Yes 2 □ No Frederick MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21701 U.S.A. 1001 Riverwalk Place Unit 132 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. ≥ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Coast Guard 12 Marine Insurance Examiner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Pidgeon Helen Frances Richard Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ; Page 1 and 2 sh tment of Health a tant: If item 27 is 1001 Riverwalk Place, Unit 132, Frederick MD 21701 Irene Pidgeon / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit, Page 1 a Department of H Important; If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 1/25/2010 4 X Donation 5 Other (Specify) Anatomy Gifts Registry Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 20 Immediate Cause (Final STAPH Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** WEEKS to MONT ASCITES Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Examine MONTHS to TEN CIRRHOSIS physician and s the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ETHANDL Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atter compileted filled in by the funeral director, page 2 should be detached for a compilete filled in by the funeral director, page 2 should be detached for a compilete of the compilete in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 26 499

State Registrar

DHMH 17 Rev 7/2009

M.D., 4 Culwell Drive, PO Box 210, Mt. Airy, MD 21771

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Miller,

Dr. Ronald E. 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 0 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 642 PM Hemantkumar Kirtikumar Parikh 2010 avuova /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford County Bel Air Upper Chesapeak Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5. Social Security Number 7. Age (In yrs. last birthday) 2010 **Funeral** Days Hours 1**X** M 2□ F 638-02-3091 41 India Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Examinar must be notified at 1 ☐ Yes 2 1 No **Funeral Director** Maryland Harford County Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21009 817 Hilltop Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2XXNo Specify Specify: Indian à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed None s 1 and 2 should be filed wi if Health and Mental Hygier item 27 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unkown Kirtikumar Parikh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 325 Bald Eagle Way, Belcamp, Maryland 21017 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tra Mr. Bibin Patel (friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel Feb. 2,2010 Forest Hill, Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—BelAir 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses - cut 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical attending pl 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐Yes 2 ☐No Severe INU 1 ☐ Yes 20 No 1 (a 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: 1 ☐ Reatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the fi 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 124 hours a TU-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler 0 D0053568

Registrar

Jeff a

31. Date filed (Month, Day, Year)

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Records,

Vital

Division of

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Januar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOMPSON

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		1	For State Registrar	Glate of Ma	, ,	Certificat	e of Death	F	Reg. No.	
			Decedent's Name (First, Middle, L	ast)				2. Date of Dea _Month	Day Y	3. Time of Death
	Physicia Medic	al L	Dean Jenkins	Pendletor	1			Januar		olo 10:25 A.M
	Examin	er '	4a. Facility Name (if not institution, gi			4b. City	Town, or Location of		4c. County of	
- /			6307 Blackburn 5. Social Security Number 6.		In yrs. last birth	idav) If Unde	Baltimor er 1 Year If Under 24			9. Birthplace (State or Foreign
	Funeral Director		216-34-2800	. D 107 -	-	/rs. Months			, Year) 1936 I	Maryland
	show at	- 1	Usual Residence of Decedent 10a. State 10b. County	T	10c. City, Town	or Location				10d. Inside City Limits
	Aaryla 8a-f s tifled	rect	Maryland N/A		Baltim	ore				1 🏋 Yes 2 □ No
	a or 2 be no	Funeral Director	10e. Street and Number			10f. Z	p Code		10g. Citizen of Wh	
	h with	Jer.	6307 Blackburn (21212	0.00 17 17 10 10 10		S.A
	r iten		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X N	er in U.S.	13. Was Dece	dent of Hispanic Origin ecify Cuban, Mexican, I	Puerto Rican, etc.)		American Indian, White, etc.
936	s after 'al", o Exam	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	0	1 🗆 Yes	2 X No Specify:		Specify:	White
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest		16a.	Decedent's Us	ual Occupation ork done during most o	of working	16b. Kind of Busi	ness Industry
21	hin 72 ne. than ' e Me	mo.	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT us	se retired)	, and the second	Univ	ersity
	filed within tal Hygiene.	as I	17. Father's Name (First, Middle, Las	4 years		1114	strator	's Name (First, Middle,		ersity
Maryland	should be file h and Mental H 7 Is marked of traumatic ever	10	Clyde Eugene 1				Marga	•	Jenkins	
JZ.	nd Me s mar		19a. Informant's Name/Relationship		19b	. Mailing Addre		or Rural Route Number		te, Zip Code)
	d 2 sk alth a n 27 k ertra		Philip R. Pendle	eton (son)	80	08 Walk	er Avenue	Baltimore,		
Baltimore,	ge 1 and 2 s it of Health if item 27 l or other tra		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	☐ Removal from State	20b. Place of cemeter	Disposition (Na y, crematory or	ame of other place)	Date		city or Town, State
Ë	Page 1 tment of tant: If it tant or o		4 Donation 5 Other (Spe	cify)	Green	Mount	Crematory	2-2-10		ore, Maryland
Bal	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Lice	ensee		Mitch 6500	and Address of Facility ell-Wiedefo York Road	eld Funeral Baltimore	l Home, I	nc. and 21212
			23a. Part 1. Enter the disease, or co	emplications that caused to one cause on each line.	the death. Do n	ot enter the mo	de of dying, such as ca	ardiac or respiratory arr	rest,	Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition		in O	struct	re Pulmi	onny Di	4-80-31	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequence o	of):				9
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	of):				
	ted 	Examiner	Cause (Disease or linjury	_		,				
	fficate be executed g physician and as the burial-transit	I Ex	that initiated events resulting in death) Last	Due to (or as a	consequence	of):			-	
90	te be nysicie he bur	Medical	•	d						
68760	ing pl		IF FEMALE:	23c. If yes, outcome of	f pregnancy				02d Data	of dolivon
Box (eath certif attending for use a	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 2 4 Pregnant at	? 🔲 Fetal deatl	n 3 ☐ Ectopi			Mont	of delivery th Day Year
B	that the dea led by the a detached f	hysi	9 🗆 Unknown	9 🗌 Unknown						
P.O.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transif	Completed by Physician/	Part II. Other significant condition	s contributing to death bu	t not resulting	n the underlyin	g cause given in Part I.	5.1		oute to the cause of death?
ds,	requires the been signed should be	ted	-anorexia							3 ☐ Probably 4 ☐ Unknown
of Vital Records,	aw recast be	uple	-depressi	/v				24a. Was	an 24b. We osy pri ormed? de	ere autopsy findings available ior to completion of cause of eath?
Re	sician: The law r certificate has k lirector, page 2 s							1 🗌 Yes		Yes 2 No
ita	ician: certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:			26. Place of Death			(0)
of V	ding Physician: The Is h. Affer this certificate hi funeral director, page	:: 12	27. Manner of Death	28a. Date of injur	v 28b.	Itpatient 3 🗌	28c. Injury at	rsing Home 5 Sesion 28d. Describe h	now injury occurred	
ou C	Attending at death. ector: Affer by the fune	icat	1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investiga		Year)	njury M	work?	No		
Division		Certificate: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			rm, street, facto	ory, office	28f. Location (S City or Tov		or Rural Route Number,
Ö	urs aff raf Di					land a same I		1	uses(e) and manner	r on stated
	the Hospital or thin 24 hours after the Funeral Dir mpleted filled in	Medical	(Chook 2 Medical Ev	Physician: To the best of raminer: On the basis of extended the praction of the basis of the bas	amination and/o	or investigation.	in my opinion, death occ	curred at the time, date a	and place, and due t	to the cause(s) and manner stated
	To the within To the compl	Σ	20h Signature and title of certifier			2	9c. License number		29d. Date signed	
			>Willey E	Ensine 1	HYSICH	1-	D 1586	28	2-1	-10
	,		30. Name and address of person w	no completed cause of de	ath (Item 23a)	(Type, Print)		ZIC RUM	1, H33	27
5			WILLIAM E			,	LUTISGI	ZUILLE 1	MID 2	1093
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	00				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# 26per PHYS, G900, 27272010, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🧷 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2010 9:30P M Piedra <u> 1</u> Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Adelphi 8402 Rambler Dr. Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min Hours 08/28/1918 1 □ M 2 🖾 F **Director** Yrs. MD 579-09-8529 91 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 □ No Prince George's Brentwood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral IISA 3501 Allison St. 20722 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married 1 Yes if Yes, Give 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12th Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Edward Collins Daisy Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3501 Allison St. Brentwood MD 20722 Nicole R. Colbert/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Olivet Cemetery</u> 1/13/2010 Washington DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home MO0 977 4217 9th St NW Washington DC 20011 mais 23a. At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 3nstrand Prits Immediate Cause (Final Ph sician/ Cerebrovascular Accident Medical resulting in death) Due to (or as a consequence of) Examiner several years Hypertension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Living Facility Other: 6X Other (Spe 2**X** No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in province in the cause in t Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, decay to the cause and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral C

> State Registrar

only one

29b. Signatury and title of certifier

Jacinth Brooks MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0.2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 Mayo Rd Edgewater MD 21037

29c. License number

D40209

29d. Date signed (Month, Day, Year)

1/11/2010

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Don J. Reed 20**1**0 Ja<u>nuary</u> 4:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gwynn Oak 1203 Ingleside Avenue Baltimore 6. Sex 1 🕅 M 2 🗆 F Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Months Hours Min. 369-14-8978 Director 89 1920 Michigan Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 Yes 2 X No Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1203 Ingleside Avenue 21207 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 \sum No 1940 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White If Yes, Give Completed 3 X Widowed 4 Divorced 1945 Specify: Year or Dates oe filed within 72 hours ntal Hygiene. ed other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Printer Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Don E. Reed Alice Hinsdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn W. Reed, Son 1203 Ingleside Avenue Gwynn Oak, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 ីX Cremation 3 🗀 Removal from State Metro Crematory Inc. 02/01/10 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death hemag Carcinometosi disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a co gequence of): nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Control of the contro ò in the past 12 months? Month Pregnant at time of death signed by the at d be detached for Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available sate has t page 2 s autopsy performe prior to completion of cause of death? Yes 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 035 0 M.P 10

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2010

32. Registy

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Thomas Charles Ragan M January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10617 Whiterock Court Laurel Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Min. March I, Year) 961 1 🖾 M 2 🗆 F Months Hours Washington DC 578-88-3637 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d, Inside City Limits 10a. State 10b. County 10c, City, Town or Location Director 1 Yes 2 K No Laurel MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e Street and Numbe Funeral 20723 USA 10617 Whiterock Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married à Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business Industryunk Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 plumber 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ဂ္ Rosemary Xela Beavers Thomas Henry Ragan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10617 Whiterock Court; Laurel, Maryland 20723 Rosemary Ragan/mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Ferric censee Wade State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ Metas ta: Medical Due to (or as a consequence of) Examiner Securativity flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No After this certificate 1 ☐ Yes 2 No iours after death.

neral Director: After this certifical filled in by the funeral director, B B 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 **X**No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Inpatient 2 🔲 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 🗋 Yes 2 🗀 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Ho.,
an 24 hours.
o the Funeral Dir
completed filler 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

D6810

Suite 4105,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death January Day 31, 2 Oa 10 3:15PM Merle Gregary Richardson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Parkville 8912 Avondale Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) July 29, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours Maryland 1X M 2□ F , 1920 214-18-9301 89 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Baltimore Parkville 1 Tyes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 8912 Avondale Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Specify: white 1 ☐Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Mechincal Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha M. Selig Noah B. Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7819 Westmoreland Avenue-Parkville, Maryland 21234 Shannon O'Brennan-granddaughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery Feb.3,2010 Parkville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 -ondrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) conord Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exertity of traumatic event,

permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ ... any injury or other traumatic even * ... *

sician and burial-transit attending physician for use as the buria been signed by the should be detached has

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician:

the

2

Examiner Physician/Medical Completed Be မ

Certification: 29a. Certifier Medical

completely filled in by the funeral director, after death.

Director: After this within 24 hours a

> 31. Date filed (Month, Day, Year) State Registrar

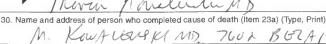
3 Suicide

4 Homicide

29b. Signature and title of certifier

6 ☐ Could not be

determined



and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Ttem 5 per fh 9900 2-19-10 vt
State of Maryland Department of Health and Mental Hygiene [] 02531 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear A. 5:05 P Hencel Rowe January 29, 2010 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 8254 Bullneck Road Dundalk Baltimore 5. Social Security Numb 233–48 - 6131 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Days Months Hours 1 X M 2 □ F 77 January 28, 1933 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 □Yes 2 🔀 No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8254 Bullneck Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify If Yes, Give Specify: White 3 ☐ Widowed 4 🂢 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 years Machine Operator Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Rowe Stella Ratcliff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Logan Friend 8254 Bullneck Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date February 1

Burial 2 □ Cremation 3 □ Removal from State Holly Hill Memorial 4 Donation 5 Dother (Specify) 2, 2010 |Middle River, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Division

and burial-tran ing physician a attending p ned by the a signed by t should I has page 2 certificate Hospital or Attending Physician: this After death. after death Director: / thin 24 hours aft the Funeral Di mpletely filled in within 2 To the I

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person

Date filed (Month, Day, Year)

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nd Mental Hygiene. marked other than

Pages 1 and 2 should be finent of Health and Mental int: If item 27 is marked or

permit. Page Department o Important: If any injury or injury or

other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after

3altimore, Maryland 21215-0036

State Registrar o completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed [Month, Day, Year)

Balt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:46 AM 01 (Jan.) Epstein 010 Bernice Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Immore Iniversity of Maryland Medical Center If Under 1 Year If Under 24 Hrs. 9. Birtholace (State or Foreign 8 Date of Birth Age (In yrs. last birthday) **Funeral** 1 M 2 K Min. July 18 Day 920 Wisconsin 395-07-5095 89 Director Usual Residence of Decedent 10c. City, Town or Potomac permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits Town or Location 10b. County 10a. State Director Maryland Montgomery 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 20854 Funeral 11710 Karen Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Specify: White Maryland 21215-0036 1 Yes 2 X No 3 XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) Homemaker (Specify only highest grade completed) 4^{College (1-4 or 5+)} Elementary/Seconday (0-12) Own Home Be . Mother's Name (First, Middle, Maiden Surname)
Mae Margol 1eS 17. Father's Name *(First, Middle, Last)* **Abraham Epstein** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 100 S. Eola Drive Apt. 1113 Orlando Florida 32801 19a. Informant's Name/Relationship (Type, Print) Michael Ritz/Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 XXCremation 3 Removal from State Towson Maryland 2/3/10 4 Donation 5 Other (Specify) 21. Signáture/of Funeral Service License reconand J. Ruck Facility 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician scotic shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a obnergiment offi cause. Enter Underlying Cause (Disease or linjury To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death Ectopic pregnancy Month Day Year 5 Other (specify) a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after deat 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29d. Date signed (Month, Day, Year) 29c. License number

12

State Registrar 22 South

32. Legistrar's Signature

mercul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rker, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		ırtment <i>tificate</i>			and M		giene Reg. N	2010	025	533		
	Physicia Medic		1. Decedent's Name (First, Middle, L.)	,	P						2. Date of De Month	ath Di	ay Year	3. Time of 0	Death M		
	Examin		4a. Facility Name (if not institution, gir Suburban Hospita				4b. City, To Bethe			of Death	,	40	c. County of Death				
I	Funeral Director		5. Social Security Number 6.	Sex 1	e (In yrs. las 54	st birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Aug • 2	Year)	1055 Cou	place (State or ntry) Land	Foreign		
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County VA Fairfax	-		Town or Loc								10d. Inside City			
:	th the Mai 3a or 28a t be notifi	Funeral Director	10e. Street and Number 2726 Fort Drive	`	11102		10f. Zip C					0	itizen of What Cou	ntry?	2 L. NO		
	r death wil or items 2 viner must	y Funer	11. Marital Status 1 □ Never Married 2 □ Married	Marital Status 12. Was Decedent Ever in U Armed Forces?						gin? (Spe	cify Yes or No- Rican, etc.)	Uni	ited Stat 14. Race - Ameri Black, White,	can Indian,			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	leted by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation									16b. l	Specify: Whi				
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Maryland 2	t be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last Herbert Joseph	,	ì		18. Mother's Name (First, Middle, Maiden Surr. Marion Wasserman						Surname)				
Mary	d 2 should alth and N 27 is ma		19a. Informant's Name/Relationship Frances D. Eby	(Type, Print) (sister)	Į.								Approximate Interval Between				
Baltimore,	age 1 and ent of Hea ent: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		ce	ace of Dispos metery, crem sapeak	atory or oth	er place	ry	Jan.			20c. Location - City or Town, State				
Baltii	permit. P Departm Importa any inju		21. Signature of Finer S rvice Lice	nsee										ion Ser	vice		
- P	nysician/	3 30	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition ATHLEROSELEROTIC CARDIOVASCULAR DISEASE												/een		
10	Medical Examiner		resulting in death)	a. Due to (or as a				,,,,,,	v / () C ·		10156						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. Due to (press	я попведы	этен об:											
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309 Box 6876	In the hospital or Attending Physician: The law requires that the death certificate be within 24 hours affect death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	ğ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	death 3 [Ectopic pre	egnancy					23d. Date of deliver Month	•	ear		
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Bran n of Vital	Attending Physician: The strength. At death. Sector: After this certificate by the funeral director, page by the funeral director, page.	잍	1 LM Yes 2 □ No 27, Manner of Death	28a. Date of inju	ry [R/Outpatien 28b. Time of		. Injury	4 ∐ Nu at		me 5 Resid		6 Other (Specifing occurred)	y)			
(app, Brian 1/26/n) Division of Vital Records,	Attending ar death. ector: Afte by the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju	ıry - At hon	injury ne, farm, stre	M et, factory, o		′es 2 □				reet and Number or Rural Route Number,				
A vio	Hospital or 24 hours afte Funeral Directed filled in	Medical Co	29a. Certifier 1 Certifying Ph	building, etc	my knowle	edge, death o	ccured at th	e time,	date and I	place, and	City or Tow	use(s) a	ind manner as stat	ed.			
1	Io the He within 24 To the Fu	Me		miner: On the basis of exurse Practioner: To the			eath occurre 29c. L	d at the icense	time, date number	and place	e, and due to th	e cause 29d. Da	(s) and manner as s ate signed (Month,	tated. Day, Year)	ner statet		
			30. Name and address of person who									7-	-26-20	0/0			
4	Sta	te	8600 OLD GEORG 31. Date filed (Month, Day, Year)	32. Redistra		BET	HESD	A	MD	208	14						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Januarv Patricia Ann Ratley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Nursing Home Lutherville TimoniBaltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 46 Yrs Sep 28. 216-92-3102 Usual Residence of Decedent Show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 21221 United States 1101-B Old Eastern Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Nancy Lee Icenroad William Franklin Ratley Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Bel Air Rd. Baltimore, MD 21206 Bonny Fiztpatrick /Niece Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jan 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility M01585 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ENDOMETRIAL CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami signed by the attending physician and detached for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 X No g Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown To the Funeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should I 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe Hospital or Attending Physician: The Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be **Division of Vital** 26. Place of Death (Check only one) Hospital: 2 🗶 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation after death Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

2010

Registrar DHMH 17 Rev 7/2009 (Check

only one

29b. Signature and title

JACKIE JONES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

2300 DULANEY VALLEY RD.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

240

29c. License number

X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Shelton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritchey Hospice Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days XXM 2 - F Hours Min. (Month, Day, Year) Director 22**7-1**8-8274 88 MD 03 - 02Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1X Yes 2 🗌 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2725 Walbrook Avenue 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married þ 1X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes XIX No Specify: Specify: American "natural", 3 Nidowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Driver Trucking Company 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Shelton Florence other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Corrine Harris-Friend 2414 Marbourne Avenue Apt.#3-A Baltimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date injury or 1 🔀 Burial 2 🗀 Cremation 3 🗌 Removal from State Garrison Forest 02-08-10 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 00 Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 6876 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 1 Yes 2 9 Unknown 2 No e has been signed by the ge 2 should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: Te law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♥ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed SHELTON 1 🗌 Yes 2 🗆 No 2 ä 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 은 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

02

32. Redistrar's Signature

31. Date filed (Month, Day, Year)

1006426

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2354 M WILBERT SIMS JAN 2010 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore N 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 D F Days Month, Day, Months Min. Year) 238-18-734 Director arolina Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d, Inside City Limits Director 1 🗖 🌿 2 🗆 No Honore 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Mcmeachen 2121 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 0 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Amatal Hygiene. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ mm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig Code) ephine revsen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State raine 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility XOT 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Depsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death be detached 9 Unknown g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed has page 2 2 🗆 No 2 🗽 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 M No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation within 24 hours after death.

To the Funeral Director: A 2 No Accident completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P19685 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Thomas

31. Date filed (Month, Day, Year)

M

Box 68760

P.O.

Records,

Division of Vital

22

32. Registrar's Signature

Pembroke

South Green St., Baltomore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 State	Department of Health and N Certificate of Death	ental Hygien) Reg. N	0.010	02537			
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	<u> </u>	3. Time of Death			
н	Physicia		WELDON SADLER		Month D 29	9 2010	7:45 a ^M			
4.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death				
and or			10323 Henry Rd. #29	Berlin		Worcheste				
	Funeral Director		5. Social Security Number 218-38-4781 6. Sex	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year 10/11/194)	r) Cou	place (State or Foreign ntry) MD			
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits			
	a-f sh	ctor	MD Worchester Berlin				1 □Yes 2 □No			
	or 28	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Cou				
	ath w	ral	10323 Henry Rd. #29	21811		nited Sta				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Marchal Expriner must be rediffed at once.	by Funeral Director	11. Marital Status 1	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecity yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh				
21215-0036	in 72 hour	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Ir	ndustry			
212	d withigiene.	E	Elementary/Secondary (0-12) College (1-4or 5+)	Pipe Insulator	Co	onstructi	on			
b	al Hy r othe	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	n Surname)				
ylai	Ment arked	2	Clifford Sadler	Helen Sch						
Maryland	nd 2 sho alth and I 27 Is ma r trauma		, (),	o. Mailing Address <i>(Street and Number or Rur</i> 646 Wall Drive, Pasad	-	-				
ore,	es 1 a of Hear		cemete	f Disposition (Name of ry, crematory or other place)	Date 20c.	Location - City or To	own, State			
Ĕ	Pag ment ant: I		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlan			en Burnie				
Baltimore,	permit. Depart Import any inj		21 Signaturi of Furieral Service Live	22. Name and Address of Facility Amb 2719 Hammonds Fy. 1						
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death			
4	Physician		Immediate Cause (Final disease or condition resulting in death)	COPD			YEARS			
1	/Medical Examiner		Due to (or as a consequence	of):						
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):						
B	uted d ansit	Examiner	Cause. Disease or injury that initiated events c.							
0,	icate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):							
38760,	sate b	dical	d							
Ψ			IF FEMALE: 23c. If yes, outcome of pregnancy	*		23d. Date of deliv	uoni.			
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23b. Was decedent pregnant to the birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year			
	that the hold by detact		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?			
rds	quires	ed by	CORONARY ARTERY DISEASI		1 XYes	2 □ No 3 □ Pro	obably 4 Unknown			
Division of Vital Records,	law requir as been s 2 should	Completed			24a. Was an autopsy	24b. Were aut	topsy findings available completion of cause of			
<u> </u>	The tate h	E O			performed 1 ☐ Yes 2 🔀	? death?	~			
/ita	clan: sertific	Be (25. Was case referred to medical examiner?		th (Check only one)					
of	Physical this call dire		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Oi 27. Manner of Death 28a. Date of Injury 28b.	·	ome 5 Residence 28d. Describe how in		cify)			
o	ding h. After funer	tion		Time of 28c. Injury at 1 Work? M 1 □ Yes 2 □ No	Zga. Describe now in	july occurred				
/isi	Atten r deat ector: by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office	28f. Location (Street		ral Route Number,			
á	tal or s afte al Dire ed in	Sert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	316)				
	To the Hospital or Attending Physiclan: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledg Medical Examiner: On the basis of examination and manner stated.							
	Vithin Vithin To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month	n, Day, Year)			
	. 1		Debantuta, M.D.	D006577	4 JA	NUARY	29,2010			
	5+1		30. Name and address of person who completed cause of death (Item 23a) Virgilio M. Bautista MD 101 Mark							
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 2010	1. barles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 239 9:25 20°f′0 Ам Steven Leon Sites Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Care, Inc. Towson If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea July 13 1 🖾 M 2 🗆 F Months Days Hours Country) Indiana **Director** 311-48-2460 62 1947 Usual Residence of Decedent 10a. State iral", or items 23a or 28a-f sho 10c. City. Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 1832 Cromwood Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates. 1 ☐ Yes 2 🛣 No Completed 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16b. Kind of Business Industryun16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) system analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph L. Sites Pauline George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Sites/brother 1017 Rosewood Dr.; Perv, IN 46970 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) Sig thre prograf Service Consee de Wards State and Address of Facility oard; 655 W. Baltimore Street me Baltimore. Maryland 21201 23a. Part1. Enter the disease, or complications that occors shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2007 Physician/ THSTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any sealing to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant a Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

DHMH 17 Rev 7/2009

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUR DOBERMAN, MS 6701 N DHARLES, SUITE 4105

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

JANUARY 23, 2010

BALTIMORE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier(e) 02539 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Ann Sophia Sapliway 11:25 P 25 January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Golden Living Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. Feb 17, Director 216-20-3481 83 1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, ITe Maxical Exert at Items to colifical at 1 ☐ Yes 21K No MD Baltimore Catonsville Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 701 Edmondson Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unk 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'na any injury or other traumatic event, II to Made. College (1-4or 5+) Elementary/Secondary (0-12) clerical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Tillie Solonnyka Samuel Sapliway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 Knox Court; Westminster, Maryland 21157 John Sapliway/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4X Donation 5 ☐ Other (Specify) 21. Signature ona S. Wader Di ector State Anatomy Board; 655 W. Baltimore Street 23a. Part1. En , the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mone /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit and the attending physician Completed by Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 \(\text{Yes} \) 2 \(\text{No} \) 23d. Date of delivery 3 Ectopic pregnancy Month Day lor 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 2□ No certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Read Westminsfe O m 31. Date filed (Month, Day, Year) 32 Aegistrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

FEB 0 2 2010

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SINGLE TON Physician/ AR-430A 2010 AN Medical lity Name (if not institution, give stre Chy, Town, or Location of Death Examiner 4c. County of Death Baltimore atonsville If Under 1 Year | If Under 24 Hrs. ast birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Month 0 ay, 1925 Director er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No baltimore 10f. Zip Code 10e Street and Numbe 10g. Citizen of What Country? Funeral 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed Slack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working | Inc. DO NOT use retired) 16b. Kind of Business Industry th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hvillmportant: If item 27 is minimy or other. 6th Be Father's Name (First, Middle, me (First, Middle, Maiden Si 2 MU 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee oreene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMENTIA Physician/ UNICOUND disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BISENSE LINICARSIAN LISNET MRONIC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Un unound HTPER REWIN -transit and Due to (or as a consequence of) resulting in death) Last -burialattending physician for use as the burial 7 E S UN KNOWN Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEMRO 1 Yes 2 No 3 Probably 4 Unknown cate has been siç page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 To the Funeral Director: After this certificate ormpleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: i within 24 hours after death. To the Funeral Director: After this certifica 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signa ATTENDIN 2010 DUO56948

Registrar
DHMH 17 Rev 7/2009

State

SME

31. Date filed (Month, Day, Year) FFR 02

ARROWNT

AZIMISKÉ

no 2129

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADMICANT

				pe or Print in				-	_	ible.	
			For State Registrar	State of Maryla		tificate of D			lene leg. No. 20	10 0254	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	re Smi	H			2. Date of Deat Month JANUAR	Day	3. Time of Death 2010 4:58 PM	
~	Medic Examin		4a. Facility Name (if not institution, give stre			4b. City, Town, or BALTIM	Location of De	ath	4c. County		
	Funeral Director		5. Social Security Number 6. Sex 1 🗆		last birthday) Yrs.	if Under 1 Year Months Days	If Under 24 H Hours Mi		1930	9. Birthplace (State or Foreig Country)	gn
	ryland t-f show ied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits 1★ Yes 2 □ N		
	ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number	e Avenu		10f. Zip Code	215		10g. Citizen of V		_
920	within 72 hours after death with the Maryland gjehe. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	by	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U Armed Forces? 1 _ Yes 2 _ No If Yes, Give Year or Dates.	J.S. 13. W		spanic Origin? (n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		e - American Indian, ik, White, etc.	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mertal Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	• Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give k	ent's Usual Occupa ind of work done d O NOT use retired)	uring most of w	rorking	Balt	impre City Schools	
Maryland	ild be filed Mental Hy larked oth atic event	To Be	17. Father's Name (First, Middle, Last) Clifton Henry	Eure			18. Mother's N	lame (First, Middlef N Zabeth	Plur	nmer	
	and 2 shou Health and tem 27 is m	38 68	19a. Informant's Name/Relationship (Type, Deborah Daught	(Daughter)	19b. Mailing	Avond	ale A	Rural Route Number, 1e., Balti		mb 21215	_
Baltimore,	~ O + E		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Place of Dispos cemetery, crem	sition (Name of atory or other place	t 21	Date 10 2010	20c. Location -	city or Town, State gs Mills mD)
Balt	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	Ireene	22. 5	Valught	foctagilites	reene Fu t'l Pilce	reval (2122	Servicus 9)	
	Hiysician/ Medical		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line.		AIN I			est,	Approximate Interval Between Onset and Death	
	Examiner	er	Sequentially list conditions, b.	1, -0.	ONIA	}				3 DAYS	
0	cate be executed physician and s the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a conse							
Box 68760	or Attending Physicians: The law requires that the death certificate be after death. Iffer death. Incorp. After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	: If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnance Other (specify)	у		23d. Dat	te of delivery nth Day Year	
s, P.O.	res that th signed by d be detac		Part II. Other significant conditions contr HYPERTENSION	ibuting to death but not re	esulting in the ur	nderlying cause give	en in Part I,		/	ribute to the cause of death?	wn
of Vital Records,	The law require cate has been si page 2 should	Completed by	DIABETES MELL HYPERLIPIDE					24a. Was al autops	n 24b. V	Were autopsy findings available prior to completion of cause of death?	ile
Vital	ysician; The nis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 M Inpatient 2	☐ ER/Outpatien	Otho	ace of Death (Co er: 4 Nursing	heck only one) Home 5 🗌 Reside	ence 6 Othe	er (Specify)	
on of	kttending PP death. ctor: After th y the funeral	Certificate:	27. Manner of Death 1 ↑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗀		28d. Describe ho	w injury occurre	ed be	
Division	tal or Attars after de al Directo		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci		et, factory, office		28f. Location (St City or Town		er or Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	an: To the best of my kno : On the basis of examinati Practioner: To the best of r	ion and/or investi	gation, in my opinio eath occurred at the	n, death occurre time, date and	ed at the time, date an place, and due to the	d place, and due cause(s) and ma	e to the cause(s) and manner sta anner as stated.	ateo
	7 vit		29b. Signature and title of certifier Say Jane Agre	awal, 1	ND	RES -	-000			(Month, Day, Year) 7 30, 2010	
	Br		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type, Pi	SINA:	I Hos	SPITAL	OF BA	LTIMORE	
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 2 2011	32. Fegistrar's Sign	B. A	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Francis Thomas Sapak Jangare 201 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 0 are 8. Date of Birth (Month, Day, Oct. 7, 7. Age (In y s. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 1⊠M 2□ F Months Davs Hours Pennsylvania 186-14-6018 86 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21234 3201 Acton Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No 1 □Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B.G. & E. Lineman/ Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Sapak Anna Mikita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3261 Harmony Rose Court, Dover, PA 17315 Ronald Sapak/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/2/2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 21. Sig rature of Funeral Service License 8800 Harford Road, Parkville, MD 21234 Approximate Interval Between Onset and Death 3a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immed ate Cause (Final disease or condition resulting in death) 5.0 Due to (r as a consequence of): olon Cancer Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

Physician /Medical **Examiner**

Department of Heal Important: If Item 2 any Injury or other

Pages '

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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artment of Health and Mental Hygiene.

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show
Injury or other traumatic event, the Medical Exercites in ast be notified at

burial-trar ed by the attending physician detached for use as the buria Physician/Medical cate has been signed by page 2 should be detach 2 Completed this certificate director, Be Certification: To funeral After

death.

Hospital or Attendi 24 hours after death. Funeral Director: # filled in by the within 24 hours a completely

1∐Yes 2∭XNo

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Division of Vital Records, P.O. Box 68760

To the I

State Registrar

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 0063974 29d. Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

IMRar

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Injury

28a. Date of Injury (Month, Day, Year)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ John Thomas Spellman, III 2010 10:54 P.M 28. Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore County Towson 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) Feb. 01, 1919 Baltimore, MD 90 Director 705-12-2134 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1812 Landrake Road 21204 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Xes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates. W.W.II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber/Steamfitter Plumbina n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Thomas Spellman, Jr. Helen May Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Wilmslow Road 21210 Mr. George W. Hyde, Jr. (Nephew) Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Jan.30, Evans Funeral Chapel 4 Donation 5 Other (Specify) 2010 Forest Hill, Maryland 21. Signature of meral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A 325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** PULMONARY DISERSE Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier JANUARY 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 4105 BALTIMONE, MD 21204

DHMH 17 Rev 7/2009

State Registrar

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Registrar's Signat

DANIEUE DOBERMAN,

/Medical **Examiner** Division of Vital Records, P.O. Box 68760, certificate this After

Hospital or Attending Physician; The law requires that the death certificate be executed and I-tran physician a s the burial-t attending p page director, funeral Director: within 24 hours a

To the Funeral I

completely filled

Physician

/Medical

Examiner

Funeral

Director

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Physician

Examine

Physician/Medical

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Completed

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Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

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Pages 1 and 2 should

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

21215-0036

Baltimore, Maryland

Smar

State Registrar

DHMH 17 Rev 1/2001

6701 N. Charles St, Baltimore MD 21204 Cynthia Soliand MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia mano un

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month, Day, Year)

1/30/10

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

Northwest Hospital Center Randal Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days Mon	2. Date of De Month Month Location of Death 11stown If Under 24 Hrs. Hours Min. Sept Sept Specify Yes or Nan, Mexican, Puerto Rican, etc.) Specify: ation	Day Year 28 2010 120 PM 4c. County of Death Baltimore rth ay, Year) 9. Birthplace (State or Foreign Country) 27 1930 Missouri 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 0- 14. Race - American Indian, Black, White, etc. Specify: white
Physician Medical Examiner	Location of Death 11stown If Under 24 Hrs. 8. Date of Bi (Month, D Sept 1 Ispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:	Day 2 Year 28 2010 1.20 PM 4c. County of Death Baltimore rth ay, Year) 9. Birthplace (State or Foreign Country) 27 1930 Missouri 10d. Inside City Limits 1 Yes 2 MNo 10g. Citizen of What Country? USA 0- 14. Race - American Indian, Black, White, etc. Specify: white
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Elementary/Secondary (0-12) College (1-4or 5+) federal employ	d)	16b. Kind of Business/Industry
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Problem 198. Informant's Name/Relationship (Type. Print) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street at 2) 19c. Richard Skoff (brother) 295 Chateaugay	and Number or Rural Route Numby	ber, City or Town, State, Zip Code)
20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or Town, State
1 □ Burial 2 M Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremati		Sykesville, MD
21. Signature of Funeral Service Licensee 22. Name and Addres P.O. Box 19		neral Home & Chapel MD 21784
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1		tobacco use contribute to the cause of death?]Yes 2 \Boxed No 3 \Boxed Probably 4 \Boxed Unknown
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examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	er: 4 ☐ Nursing Home 5 ☐ Re	sidence 6 Dother (Specify) hospice
27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work Work 1 Natural 5 Pending (Month, Day, Year) Note of Injury Work Investigation	ry at k? 28d. Describe	how injury occurred
25. Was case referred to medical examiner? 1 Yes 2 No 27. Manyer of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28e. Place of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office determined 29e. Certifier (Check only one) 29e. Signature and title of certifier) 29e. License	28f. Location	(Street and Number or Rural Route Number, own, State)
29a. Certiffer (Check only one) 29b. Signature and title of certiffer) 29c. License		
29c. License	se number	29d. Date signed (Month, Day, Year)
MSKajapahseM.D.	D0057465	1/28/10
(Check only one) Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated. Signature and title of certifier 29c. License 2	203, Baltime	ore, MD. 21209.
State Registrar FEB 0 2 2010 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 31°, 2010 8:48 A M DORCAS GALE SNOW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Elkton Union Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Apr. 6, 1920 1 □ M 2 🔀 F Months Virginia Director 89 23-10-5589 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 28a-f 1 Yes 2 No Maryland Rising Sun Cecil 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? must be 23a Funeral USA 21911 15 Octoraro Park Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: "natural" 3 ₩ Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental P Charles Henry Sult Ida Virginia Pauley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Octorara Park Lane, Rising Sun, MD 21911 Health attem 27 Patsy Simpson / Daughter 20a. Methpd of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o = 0 1 St Burial 2 N Cremation 3 ☐ F 4 ☐ Donation 3 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 4 Donation of Faith Cem. Baltimore, Maryland Gardens ure of Fureral Service L 21. Signat 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Par 1. Inter the livease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician/ disease or condition resulting in death) Prieumo Nia Medical Examiner SIEPSI 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consecuence of: Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Dav Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 X Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral I Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065733 6.1. Nanto ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKTON, MB - 21921

Registrar DHMH 17 Rev 7/2009 126 A

32. Registrar's Signature

E. HIGH

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RAD V. PULA

NARAYANA

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item 20c per fh g900 2-2-10 vt
State of Maryland / Department of Health and Mental Hygiene 20 10 02547 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ANUARY Physician/ 02:35AM 2010 JOHN DOUGLAS SCHWORM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 9. Birthplace (State or Foreign Country) MA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 6. Sex 1 🛣 M 2 🗆 F 7. Age (In vrs. last birthday **Funeral** Days Min. Months Hours 1057 08/T925 84 Yrs Director 263-28-6997 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No TIMONIUM BALTIMORE MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral or items 23a USA 404 ROCKFLEET ROAD. #104 21093 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify "natural", Completed 3 Widowed 4 Divorced WHITE Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. arked other than College (1-4 or 5+) Elementary/Seconday (0-12) be filed within DISABILITY EXAMINER SOCIAL SECURITY ADMIN. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked o ည **DOUGLAS SCHWORM** VIOLET JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 ROCKFLEET ROAD, #104, TIMONIUM, MD 21093 LOIS SCHWORM / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot CROWNSVILLE OWINGS MILLS, X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) MARYLAND VETERANS 2/1/2010 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service License Signatur 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician STAPHYLOCOCCUS BACTEREMIA disease or condition Medica! resulting in death) Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit END STAGE RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: No Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) မှ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at injury Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day Year) Signature and title of certifie 29c. License numbe MO 2010 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER OSLER DRIVE MARYL AND F. 7621 TOWSON. 32. Fegistrar's Signature State ensur. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Taddeo January 2010 10:49A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 339-A Woodpoint Avenue Hagerstown Washington 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 X F Director 216-14-6092 86 06/24/1923 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Washington Hagerstown MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 339-A Woodpoint Avenue 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 X Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Meany Elementary/Seconday (0-12) College (1-4 or 5+) 8 Cook Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary John Edward Waters Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339-A Woodpoint Ave., Hagerstown, MD 21740 Anthony Taddeo / Son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatamy Gifts Registry 2/2/2010 Hanover, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 700 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, asm disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner consequence of) the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execuvithin 24 hours after death.

To the Funeral Director: After this centificate has been also as a feet of the Funeral Director. resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

OPAL CT., HAGTERSTOWN, IND 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

COFFECE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 09:18 AM 10 Jar 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner $\Lambda /$ 51. Agree 5. Social Security Number HOSPITA 6. Sex Baltinore Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min. 1 M 2 F Hours Months 214-24-0503 Director 119 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experiment runst be notified at 1 ☐ Yes 2 ☐ No Funeral Director Hmore 10g. Citizen of What Country? 10e. Street and Number 3324 G 10f. Zip Code USA 21214 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 🖼 🗥 o Specify 2 Specify: lack 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Syrname) 17. Father's Name (First, Middle, Last) Be av se 161 ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once. Stown, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State udor 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 2120 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Septicemio ZYAC disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director; filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3
Suicide determined 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Verro 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 CATON
32. Registar's Signature Avehue, Baltimore, Maryland Sangifa Va 31. Date filed (Month, Day, Year) Verma State

DHMH 17 Rev 1/200

Registrar

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Daniel David Tal		1- For State	ate of Maryla		ment of ficate of		Mental H		20	10 0255			
Physicia	ın/	Registrar 1. Decedent's Name (First, Midd	le,Last)					2. Date of De		3. Time of Death			
Medical Exami	ner	Daniel David T	ablante, J	ſr.				Month January		1330 hrs			
		4a. Facility Name (if not institution 6658 Roberts Court #	· -	mber)	4	b. City, Town, or L Glen Burnie		l		4c. County of Death Anne Arundel			
Funeral		5. Social Security Number		7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24Hrs	8. Date of B		9. Birthplace (State or			
Director					Hours Min.	10/04	/1977	oreign Country) MD					
	ł	Usual Residence of Decedent	1 1/23 =				l						
v any	ĺ	10a. State 10b. County MD Anne	Arundel		wn or Location					10d. Inside City Limits			
land f show once,	ē			01011	During					1 Yes 2 No			
Maryla	Director	10e. Street and Number 6658 Roberts C	ourt #98			10f. Zip Code 21061			10g. Citizen of What	States			
vith the N s 23a or 7		11. Marital Status		edent Ever in U.S.	13. Was	Decedent of Hisp	panic Origin? (Sr	pecify Yes or N		American Indian, Black,			
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after c	by F	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	X	1	Yes 2 No	specify:		Specify:	White			
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36 nin 72 than dical	plet	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	Disab	led			Disabl	ed			
5-00 ed with	Completed	17. Father's Name (First, Middle			-	18			Maiden Surname)				
215 be file ental H rrked	Be	Daniel David							Thompson				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a Informant's Name/Relations Virginia Thom		hor					imber, City or Town,				
and 2 lealth 2 tem 27	ŀ	20a. Method of Disposition	-			ion (Name of cem		Date	Burnie,				
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Baltimore, permit. Pages I ar Department of Hee Important: If itel	1	4 Donation 5 Other S 21. Signature of Funeral Service	pecify:				1		<u> </u> 	me. Inc.			
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Examiner		Immediate Cause (Final disease	a Combine	ed drug (methad	lone nad	alprazo	lam) i	ntoxicatio	on Death			
		or condition resulting in death)	Due to (or as a	consequence of):									
	ē	Sequentially list conditions, if any, leading to immediate		nonsequence or)									
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OX 68760 eath certificate t rattending physi	cian	past 12 months?	I - Live oi	rth ant at time of death		aldeath 3. <u>.</u> er <i>(Specify)</i>	Ectopic pregna	псу	Month	Day Year			
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Dj ospital hours a neral l	ခ် ပ	4 Homicide	rmined (Specify)										
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	ledical	(Check only Certifying P	hysician: To the best miner:On the basis o	f examination and/									
To To To Com	Med	29b. Signature and title of certific	and manner st	ated.		29c.License	number		29d. Date signed	(Month, Day, Year)			
		1/1 2	W "01	7,	λ	O.C.N	1.E. 0	CME	January 24,	2010			
d	ł	30. Name and address of person	who completed caus	e of death (Item 23		l		- 60	<u> </u>				
W		Theodore M. King, Jr.		nt Medical Exa	aminer	111 Penn Stre	eet, Baltimore	e, MD 2120)1				
St	ate	31. Date filed (Month Day Year)	32. Re	gistrar's Signature	arket								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Page A. Tillett Month JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Saint Joseph Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. Funeral 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 M 2 K NC Director 82 228-20-8993 1927 Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 XNo 10e, Street and Number 10g. Citizen of What Country? Funeral 12107 Tullamore Ct. #304 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 XWidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Medical/Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ဂ္ Leonard Cleveland Anderson Mattie Grimstead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Tillett Rimorin/daughter 474 Riverside Dr., Pasadena, MD 21122 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/28710 1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Valley Memorial Gardens Dulaney Timonium, MD 22. Name and Address of Facility Lemmon, Funeral Home of Dularey Valley 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Se Vine License Michael J. Hagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ CARDIOGENIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VENTRICULAR ARRHYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir death certificate be executed MITRAL VALVE REGURGITATION Due to (or as a consequence of) resulting in death) Last burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? LACTIC ACIDOSIS 24a. Was an page performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 1 No Hospital: Other: ျပ 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending work? s after death. I Director: Aft 2 Accident 3 Suicide 4 Homicide 2 🗌 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral D Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10 v

State Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month," Dav. Year) 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINTHICUM,

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M.D.,

DHMH 17 Rev 7/2009

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3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D 31826

7601 OSLER DRIVE, TOWSON, MARYLAND21204

29d. Date signed (Month, Day, Year)

1-26-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 ATRICIA 013 RAINUR U Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1102 Inner Circle Brooklyn Baltimore City Funeral 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min. July 31, 1938 Director 212-36-1246 71 MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City Brooklyn 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1102 Inner Circle 21225 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc 1 Never Married 2 Married b Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Packer Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Trinkaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Lois Stankiewicz/Daughter 1102 Inner Circle Brooklyn Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February Cedar Hill Cemetery 4 Donation 5 Other (Specify) 4, 2010 Brooklyn Park, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1, Natural injury 5 Pending 2 | No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Number Pranticioner To the best of my included coefficients of the time, date and place and one to the cause and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21438 012010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print EFENSE HOHWA

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 0 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donna Ann Titus Month 5:00 January 29 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caton Manor Nursing Home Baltimore n/a 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Yo October 18 1 🗆 M 2 🖵 F Months Days Hours 1949 Maryland 213-52-7946 60 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD n/a **Baltimore** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1924 Light Street 21230 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 K Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald H. Williams Annalis Bodenschatz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page ,
Department of Hea_{ls}.
"nortant: If item 27 Lisa Reeder daughter 4302 Belle Of Georgia Ave. Pasadena , MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Feb. 5, 2010 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee NA CO <u> 130 Fast Fort Avenue Baltimore, Maryland 21230</u> not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) e cu-Medical Due to (or as a conseque Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 304 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? a No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident ☐ Suicide 2 🗆 No Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, Day, Year)

FEB 02

10-00386 Genaro S. Uy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 02554

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Physici edical Exam			le,Last)							Date of De Month January	ath Day 13, 2010	Year	3. Time of Death 1355 hrs
)		4a. Facility Name (if not institution 10912 Inwood Avenue		mber)	4	b. City, Town, Wheaton	or Lo	ocation of	Death			inty of Dea tgomery	
Funeral Director		5. Social Security Number Un						Min.			Fore	irthplace (State orunk ign ountry)	
		Usual Residence of Decedent		59		<u> </u>			<u></u>	Apr 4	1950		
r any		10a. State 10b. County		10c. City, Tow	n or Locatio	n							10d. Inside City Limits
Maryland 28a-f show d at once.	호		gomery	Wh	eaton								1 Yes 2 No
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Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should b	Certification:	dete	a not be	e of Injury - At home, to residence	rarm, street	, factory, οπιο	e Duile	aing, etc.		or Town,	State)		ural Route Number, City Vheaton, MD
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Fo the vithin of the complete	Medical	one) 2 Medical Exa	miner: On the basis of and manner st	of examination and/or ated	investigatio	on, in my opini	ion, de	eath occu	urred at th	ne time, date	e and place, a	nd due to t	he cause(s)
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		Tate Wie	mila-	Toller	10	0.0	C.M.	E.			January	/ 14, 201 	U
		30. Name and address of person Patricia Aronica-Polla		e of death (Item 23a) I nt Medical Exar		111 Penn	Stree	et, Balt	imore,	MD 2120)1		
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Regis		CCDAA	2010	was M.	BALL								

10-0053	39
Mary J.	Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day January 19, 2010 Medical Examiner 1556 hrs Mari 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2702 Keyworth Avenue **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Director Months Hours Country) 1 M Usual Residence of Decedent E S 10a. State 10b. County 1 Yes 2 No 28a-f show 23a or 28a-f sho notified at once, Pages I and 2 should be filed within 72 hours after death with the Maryland nont of Health and Mental Hygiene.
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To the Funeral Lirector: A 1 X Natural Pending 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. January 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

State Registrar

. Registrar's Signature ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 25, 2010 Anna E. Webb 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Nov • 16, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign . Year) 914 1 □ M 2 🖵 F Maryland 95 214-03-1831 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Harford Fallston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1800 Abelia Road 21047 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No 14. Race - American Indian. 11. Marital Status 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2\times No Specify. Specify: White 3 ₩idowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Hosiery Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph H. Metzger Eleanor (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Schmitt / Daughter 1800 Abelia Road Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 28, 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gar 4 □ Donation 5 □ Other (Specify) 2010 Fallston, Maryland re of Funeral/Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-Bel B Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Immediate Cause (Final disease or condition resulting in death) 21/61 Due to (or as consequence of): mone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Z☐No 20 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 1 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Physician /Medical **Examiner**

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death certificate be executed physician the the attending is been signed by the 2 should be detache The law requires that this certificate has page 2 Attending Physician: after death Director:

Examiner Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant

29a. Certifier

 Location (Street and Number or Rural Route Number, City or Town, State) Poertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

- Chesapeake Dr.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

500 Nunamusa 31. Date filed (Month

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norma Lee Woods 21:15 ™ 1/13/2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🏝 F Days 402-60-3408 10/30/1938 71 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 12325 New Hampshire Ave 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 🛮 No Specify: 3 Widowed Divorced Specify Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Frank Riley Edna McKinney 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Sizmore / Daughter 379 Roy Campbell Drive, Hazard Treva 41701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Riffey McKinney Cemetery 1/20/2010 Lee County, 4 Donation 5 Other (Specify) of Funeral Service Licensee Victor Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 21. Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 30min Physician/ Acute Coronary Syndrome disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 6 months Coronary Artery Disease Sequentially list conditions, if any leading to many clate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXInknown Diabetes Melliutus Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s 1 Yes 2 No Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ANursing Home 5 Residence 6 Other (Specify) 2XX No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined To the Hospital Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar (Check

29b. Signaty

only one

no title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WHOV

Ran Passi, MD 15245 Shady Grove Rd# 130, Rockville MD 20850

32. Registrar'

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

1/15/10

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 129 1010 Month Mary E. Wrench anuary 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death County of Death Baltimore HOSPITA Randallstown Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 212-46-9554 1□ M 2 😿 F Months Hours Min 94 19 1916 Jan MD Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5205 McFaul Road 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify. Specify Black 3√Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th ΝĄ Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Sewell Daisy Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Pagen - Daughter 5205 McFaul RD Balto. MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 02/05/2010 Randallstown, MD 21. Signatule of Funeral Service License 22. Name and Address of Facility March F/H 4300 Wabash Ave. Balto. MD 21215 23a. Pa t1. Enter the divease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Cardiovasular Disease Atherosi ears disease or condition resulting in death) Due to for as a consequence of): bute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗆 🌃 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident 5 Pending

Physician /Medical Examiner

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death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the Innertal director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran

Physician/Medical Examiner Certification: To

3 Suicide

29a. Certifier

4 Homicide

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

investigation

determined

6 ☐ Could not be

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

old Court Rd, Randall stown MP lason 5401

31. Date filed (Month, Day, Year) 32. Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 31, MARY EVELYN WITZKE 2010 4:40A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Dulaney Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. July 16, 1924 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Virginia 230-18-6567 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2□No Maryland None Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6100 Dunroming Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XIX No Specify: Specify: White 3XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee McGraw Minnie Reedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil W McGraw Nephew 42547 Anne Court Hollywood Maryland 20636 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gardens Feb 4,2010 Timonium, Maryland Sgnature of Fune II a ryce Licen 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease shock, or heart failure. I e, or complic List only or Immediate Cause (Final disease or condition resulting in death) RENAL CHRONIC Due to (or as a consequence of) years. Sequentially list conditions, If they bearing to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, the nse ed by the a ign be page Physician:

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Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical Examiner

Completed by Be Certification: To

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

State Registrar

or Attending

Hospital

hel. MD 14.1)

5 Pending investigation

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSER Dr. TOWSON MD 21204 7600

32. Registrar's Signature 31. Date filed (Month, Day, FEB 0 2 2010

To the

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A Month RY 2 Year 0 03:40A M Winand Bruce Hurst Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Joseph Medical Center Cowson imare 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Day, Year) 1<u>959</u> Month, Dec 9 1 🛛 M 2 🗆 F Months Days Hours Min Maryland Director 219-58-6132 50 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 14 Fox Knoll Court 21093 USA within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Ifth and Mental Hygiene.
27 is marked other than "rr traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 04Sales Representative Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any injury or other traumatic once, William Thomas Winand, Jr. Adela Be11 Hurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Pace Winand/Wife 14 Fox Knoll Court, Timonium, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/1/10 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Enter t e disease, or complessor k, or hear failure. List only on cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immedia e Cause final disease or condit n resulting in the h) Onset and Death Ph sician/ ARDIAC ARRHYTHMIA Medical Due to (or as a consequence of) Examiner CARDIOMEGALY Sequentially list conditions Examine Due to (or as a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 1 ☐ Yes 2 ☐ Unknown **leral Director:** After this certificate has been signed by the filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEPATOSPLENOMEGALY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy performed? Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital 1 ☐ Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DØØ6Ø495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 1246PM JOHN WELK JAN 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Howard County General Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) 04/27/1937 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 212-34-5490 1 M 2 □ F 72Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other tranmatic event, the Medical Exp. inpur mat be notified at ury or other traumatic event, the Medical Exp. inpur mat be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be confibed at Md Howard Ellicott City 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3041 Patuxent Overlook Ct. 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12Yrs. College (1-4or 5+) Port Of Baltimore Heavy Equipmemt Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Miller John Charles Welk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3041 Patuxent Overlook Ct. Ellicott City, Md 21042. Loretta Jean Welk(Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Sykesville, Md. All County Cremation 02/02/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel P.A 21. Signature of Funeral Bervice Licenses P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DISSECTION disease or condition resulting in death) HORTIC /Medical Due to (or as a consequence of): **Examiner** ARTERIOSCIEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👺 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 💹 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) evan Kuch D25004.

Registrar
DHMH 17 Rev 1/2001

State

Saltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

HOWARD CO GEN HOSP.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Amend #30 per DVR e900 2/2/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 12:09 A^M January 29, 2010 Dennis Wilson Eugene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4524 Raspe Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ➡ M 2 □ F april 15, 1953 Maryland Director 56 220-48-0066 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. MD N/A Baltimore 1XIYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA 4524 Raspe Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Clerk Grocerv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Evelyn Parsons Rueben Donald Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3204 Putty Hill Avenue Baltimore, MD 21234 Donald Wilson- Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/3/2010 Baltimore, Maryland 4 Donation 5 Dother (Specify) Gardens of Faith 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, MD 21206 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 W1 Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 D 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this After thi funeral (27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hin 24 hours af the Funeral Di mpletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and the of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Panayiotis A. Baltatzis, MD 8113 Harford Rd, Suite 100 Baltimore, MD 21234 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Division of Vital Records, P.O. Box 68760,

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ysician Medical	1. Decedent's Name (First, Middle, Last)	\	Wearins	2. Da	ate of Death onth Day	Year 2010 O 9 3 O AM
aminer	4a. Facility Name (If not institution, give street a The Johns Hopkins Hospit 5. Social Security Number 6. Sex	7. Age (In yrs. last bir	Baltimore	City If Under 24 Hrs. 8, Da		9. Birthplace (State or Foreign
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e notified a	10e. Street and Number	Dair	10f. Zip-Code		10g. Citizer	n of What Country?
ral C	1923 E. Baltimore s	t.	2123:	L	Un.	ited States
any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married 1 If Y	is Decedent Ever in U.S. ned Forces? Yes 2' S. No es, Give ar or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Specify Yean, Mexican, Puerto Rican, Specify:		. Race - American Indian, Black, White, etc. Native pecify: American
t, the Medical E.	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Coll		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16b. Kind	d of Business/Industry
C C	6		Home Maker	40 Mathada Nassa (First		n Home
even	17. Father's Name (First, Middle, Last) Charlie Lowery			18. Mother's Name (First		urname)
matic 70	19a. Informant's Name/Relationship (Type. Prin	nt) 19b	b. Mailing Address (Street	and Number or Rural Rous		Town, State, Zip Code)
er trau	Sharon Wearins /Daug	hter	1513 Becklo	w Ave. Middl	le River,	MD 21220
ry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	i ii diii diato	of Disposition (Name of ery, crematory or other place apeake Crema) Uai	1 30,	tion - City or Town, State
ian ical ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uisease or injury that initiated events c.	oue to (or as a consequence	8717 Greenot enter the mode of dying of:		rive Towso	n Maryland 21286 Approximate Interval Between Onset and Death
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0 0				 -	1 Yes 2 3 4a. Was an autopsy performed? Yes 2 No	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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I in by the funera ertification:	1 Natural 5 Pending 2 Accident investigation			?? Yes 2 □ No 28f. Lo	escribe how injury of the control of	occurred Number or Rural Route Number,
ppletely filled	(check only 2 Medical Examiner: Or	To the best of my knowledge the basis of examination and manner stated.	e, death occurred at the tind nd/or investigation, in my o	me, date and place, and du ppinion, death occurred at	ue to the cause(s) at the time, date and p	nd manner as stated. blace, and due to the cause(s)
ocup We	29b. Signature and title of Certifier		29c. Licenso	e number	29d. Date s	signed (Month, Day, Year)
	Eric Zolais	ed cause of death (Item 23a)	(Type, Print)	600 Nort		Baltimore, MD, 2128
State gistrar	FEB 0.2 2010	32. Registrar's Signature				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 Year 28, John George Zera January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL TOWSON CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Director 173-22-7415 PÁ 81 Dec. 31 1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore **Timonium** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 237 Coldbrook Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □**X**10 Specify ģ Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any Injury or other traumatic event, Its. ORGE. 4 Shipping Agent Shipping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Zera Agnes Ryan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Zera, Jr./son 49 Cinder Rd., Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/2/10 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Dalaney Valley Memorial Gardens 4 Donation Timonium, MD 22. Name and Address of Facility Lemmor Funeral Home of Dulaney Valley, Inc. W. Padonia Rd., Timonium, MD 21093 Clary W. Bryan 23a. Part 1. Enter the disease, or complications that caushock, or lifeart failure. List only one cause on ear ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob co use contribute to the cause of death? ⋛ 2 🔲 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 □ Yes Hospital or Attending Physician: 25. Was case referred to examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient filled in by the funeral dir Certification: To 2 ER/Outpatient 3 DOA After this 27. Man of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗆 Yes 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

To the I within 2.

Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 29b. Signature and Itle

30. Name and address of person who comp

Year)

29d. Dale signed (Month, Day, Year)

and manner stated

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Year 10, Stanley Conrad Andrews January Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 1 ፟ M 2 □ F Months Days Hours 16,1938Washington DC Director Yrs. 579-50-4523 August Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3211 19th Street, North West 20010 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Yes 2 [If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", 3 X Widowed 4 Divorced 1956 Specify: Completed **Black** Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the years Grant Overseer Department of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental E is marked of ၉ John Andrews Henrietta Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau Ponti Andrews/Son 19th Street, North West, Washington, DC 20010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🛮 Burial 2 🔲 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill 01/16/2010 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. Georgia Avenue, NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death Month g Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Endstage Renal Disease Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performe Yes 2 No 1 Yes funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🙀 No Other: ဂ္ 1 X Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of I Director: After to in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2:30 A M

1 Nes 2 □ No

Approximate Interval Between

Onset and Death

Day

2 🗆 No

January 10, 2010

Year

DHMH 17 Rev 7/2009

State Registrar

5+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sayed Eisayyad 31. Date filed (Month, Day, Year D0062435

9901 Medical Center Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ALBRIGHT - DELLA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western Maryland Regional Med. Ctr. Cumberand Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 6 - 22 - 1 6. Sex **Funeral** 1 □ M 2 🔀 F 213-22-3252 89 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director Bedford HUNDMAN PA 10e. Street and Number Funeral M:11 Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 27 is marked other than "natural", or iter traumatic event, the Medical Examiner Completed by 1 Never Married 2 Married 2 **N** No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ TROUTMANS awson Victor KATHRYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Albright 11108 Ave NE Comberland injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1-21-2010 4 ☐ Donation 5 ☐ Other (Specify) HYNDMAN CEM. 21. Signature of Funeral Service License 22. Name and Address of Facility 169 clarence st Harvey H. Zergler FH Irc 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ence Phalalathy Broxic disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an autopsy performed? 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the SUDKEER SANKOMMU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHEER SANIKOMMU mo, 12501 Willowbrock Rd Cumberland MO 21502

02566 3. Time of Death 2115 M 4c. County of Death Allegany 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian. Specify: VVhite 16b. Kind of Business Industry Home EDNA MO 2150Z 20c. Location - City or Town, State HYMOMAN HYWOMAN PA 15545 Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number,

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ _Month Year JOHN WILLIAM ADAMS, Jr. 142 lanuar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Memoria Hospita alb ston 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours Min. Virginia 579-38-1591 Director 80 Oct. 929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Talbot 1 Yes 2 X No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Choptank Avenue 21601 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Painting Hygiene. Elementary/Seconday (0-12) College_(1-4 or 5+) Self Employed Contractor Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F 2 be John William Adams Mary C. Etter permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or other traumatic ence. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan D. Adams - Wife 203 Choptank Avenue Easton, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State National Mem'l Park 1/13/2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility EVERLY FUNERAL HOME Signatur Yare 10565 Main Street Fairfax, VA 22030 23a. Part 1. Englet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) a Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No certificate has been signed by the a rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ie Hospira. in 24 hours affer death. the Funeral Director. After this certificate 2 10 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 10 ၉ 1 Supatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

Registrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02568 Reg. No. Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month S Athey Ann 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Allegany WHMS- RMC Cumberland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Feb 10, 1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 □ F Months Hours MΩ 213-40-3936 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 1 □Yes 2 □ No Cumberland MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 401 Wempe Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black White etc 1 □ Never Married 2 Married 1 □Yes 2 □No Specify. If Yes, Give Year or Dates: Specify white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude E. (Ellsworth) Offutt Charles S. Offutt, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 401 Wempe Drive Cumberland Raymond Athey Jr. son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter & Paul Cemetery 1/15/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple sclerosis with complications Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to (or as a nunselytience of): 23d. Date of delivery Month Year use contribute to the cause of death? ! ☐ No 3 ☐ Probably 🌿 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

Director

Funeral

Completed by

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th and Mental Hyglene.
?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mostical Exertine must be notified at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Physician/Medical Examiner physician and s the burial-trans as use jo signed by the a Š Completed page 2 should funeral director. Be Certification: To After this

23

Pa

27

Division of Vital Records, P.O. Box 68760,

Cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed? 1 Yes 2 2 2 2 2 2 2 2 2
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? → Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day, Year) Injury Work? ion M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not		8f. Location (Street and Number or Rural Route Number,

the Hospital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director; Af within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and tipe of certifie 31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IMPERLAND MD 24 W 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month WNVary Year HASSAN NASSER Al-Khamis /Medical 9:45 AM 2010 4a. Facility Name (If not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) **Director** None 948 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Heatth and Mental Hygiene. 10a. State 10b. County 28a-f show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 □ No nove 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral United Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 "natural", or ģ 1 Yes 2 No 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government ngineer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other ti any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) HASSAN NASSER AL-KHAMIS ပ္ FATIMA MOHAMED 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 President AL. KHAMIS ESAM SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 21/2010 Dubai, 4 Donation 5 Other (Specify) Dubai 21. Signature of Funeral Service Licensee hill VA.22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and difor use as the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Month Day Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Bladder Completed 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: Ine law within 24 hours after death.

To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 1 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) ပု 1 Yes 2 X No 1 Inpatient 3 🗆 DOA 2 ER/Outpatient 27. Magner of Death 28a. Date of Injury (Month, Day Year, Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of sertific 29c. License number 29d. Date signed (Month, Day, Year) MD RES- 000 17 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khatri Rina MI 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 9 2010 Registrar Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /	-			lental Hyg	jiene		
			Registrar 1. Decedent's Name (First, Middle, Last)	Certi	ificate of L	Jeath	2. Date of Dear	eg. No. 2	010	0.2570
	Physicia						Month	Day 7	2010	1:58 pM
	/Medic Examin		Catherine M. Appleby 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death			y of Death	
ang mar pi			Union Hospital		Elkton			Ceci		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 7 – 11 –	Year)	Cour	place (State or Foreign atry)
	Director		221-10-0709 12 M 28 F 90 Usual Residence of Decedent				7-11-			
	show	_	10a. State 10b. County 10c. City, To DE New Castle Bear	wn or Loca	ition				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma	ecto	DE New Castle Bear 10e. Street and Number		10f. Zip Code			l Og. Citizen of	What Cour	
	with t	١	1729 Bear-Corbitt Rd.		19701			USA	TTIQC OOG	,.
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Mydical Evan her out be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever In U.S. Armed Forces?	13. W	as Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		ace - Americ	
36	or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		Tes, specify Odba □Yes 2 ½ No	Specify:	Thours, otor,		ify: Whi	
21215-0036	hours tural"		3€ Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16	6a. Decede	nt's Usual Occupa	ation		16b. Kind of	Business/In	dustry
215	an "na an "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kii	nd of work done o O NOT use retired	luring most of work	ing	_		/D-4-:1
2	ed witl ygiene ier tha	Completed	12 2	Cred:	it Man	ager				e/Retail
and	ould be file Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last) David Aubrey McMullen			18. Mother's Nam		Maiden Surna Hushe!		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item traumatic event, it. " dical Exaction and the notified at	은		9b. Mailing	Address (Street a	and Number or Rui	al Route Numbe	r, City or Tow	n, State, Zip	Code)
	1 and 2 s Health ar tem 27 is					Rd., El			1921	
Baltimore,	of He if item	8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposit	tion (Name of story or other plac	e) 1 2	Date	New (
Ĕ	t. Pag tment tant: ijury o			celav	wn Mem.	PK. 1-2	3-2019			
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Agritude of Funeral Service lice is e	2.	12 N. B	road St	MIELS Middl	ome etown	PE:	N FUNERAL 19709
	Physician / Medical Examiner bhysician and sthe privilensit sthe privilensit sthe privilensit street stree	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause) Due to (or as a consequence cause) Due to (or as a consequence cause)		tic are	h sleer	m o	Snec	feer s	Onset and Death Yhours Every Wk)
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pit completely filled in by the funeral director, page 2 should be detached for use as it completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal der 4 ☐ Pregnant at time of death	ath 3 🔲 I	Ectopic pregnancy Other (specify)	ý			Date of delive	rery Day Year
Vital Records, P.	uires that n signed to Id be deta	by	Part II. Other significant conditions contributing to death but not resulting A cute weigt failure	g in the und	derlying cause give	en in Part I.		Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
Ö	aw requir ts been s 2 should	Completed	Fscheric Pascrestitis				24a. Was autop		o. Were auto	opsy findings available ompletion of cause of
m m	Physician: The law in this certificate has and director, page 2 a	Com	Probable ischemic bows	e/			perfor	med? 2 No	death?	2 □No
Vita	ician: certifik ector,	Be	25. Was case referred to medical examiner?		2 DOA Oth	26. Place of Dea				
ō	Phys er this eral dir	: To	27. Manner of Death 28a. Date of Injury 28l	b. Time of	28c. Injur	y at	ome 5 Residence Residence Page 1			ify)
on	nding Ph ath. r: After th e funeral	atior	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	M 1 🗆	ć? Yes 2 □No				
Division of	or Attene after death Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location (S City or Tox		mber or Rui	ral Route Number,
Ω	pital o		29a. Certifier 1 Certifying Physician: To the best of my knowlet	dae death	occurred at the ti	me date and place	and due to the	cause(s) and	manner as	stated
	To the Hospital or Attenwithin 24 hours after deation to the Funeral Director:	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowler (Check only one) Medical Examiner: On the basis of examination and manner stated.	and/or inve	estigation, in my c	ppinion, death occu	rred at the time,	date and plac	e, and due	to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier		29c. Licens			29d. Date sig	ned (Month	, Day, Year)
		6	aff at me		1000	5519	0	Janvai	y //	7,2010
			30. Name and address of person who completed cause of death (Item 23			106 B	. L. C. J			
	Sta	te.	ALTICA A PINO WD VIA 31. Date filed (Month, Day, Year) 32. Registra's Signature		tospital	100 Di	OW JAN	6/		
	Registr		IAN 2 1 2010 > Beneral	A.	1 anta					

Physic /Med Exam

Funeral

For State Registra AMEND#12perINF	•		tment of Health and M <i>ificate of Death</i>		i. No.	025/		
1. Decedent's Name (First, Middle, Las				2. Date of Death		3. Time of Death		
	th			Month January	Day Year 11, 2010	10:45 a		
4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death		4c. County of Deat	h		
Brooke Grove Nurs			Sandy Spring	151	Montg			
5. Social Security Number 399-14-5774 Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) March 30	(ear) 9. Birt Co 9, 1924 W	hplace (State or Forei untry) isconsin		
10a. State 10b. County	10c. Ci	ty, Town or Loca	ation			10d. Inside City Limit		
Maryland Mont	gomery Ro	ckville				1 □Yes 2 🕅 N		
10e. Street and Number			10f. Zip Code	100	g. Citizen of What Co	untry?		
12702 Parkland			20853		USA			
11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? Mar 1 1 Tyes 2 1 19 If Yes, Give Year or Dates: 196	622	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto □Yes 2♠ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.		
15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decede	ent's Usual Occupation and of work done during most of work		6b. Kind of Business/	Industry		
Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	O NOT use retired)		34- 31			
17. Father's Name (First, Middle, Last)	1	Lab	oratory Technicia 18. Mother's Name	an e (First, Middle, Ma	Medical aiden Surname)			
William Henry Be	eth			t McCorr				
19a. Informant's Name/Relationship (7		19b. Mailing	Address (Street and Number or Rur			Zip Code)		
Janet F. Beth/Wif			Parkland Drive,					
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	•	tion (Name of tory or other place) hington Cemetery	Jan. 15 2010	Oc. Location - City or	Town, State Maryland		
21. Signature of Funeral Service Licen	ander		Amens Address Con Vins O University Blvd	Funeral	Home Inc.	,		
Sequentially list conditions, if any, leading to immediate cause. Example 1 to the first Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect c.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions c	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown ontributing to death but not res	al death 3 ☐ death 5 ☐	Ectopic pregnancy Other (specify) derlying cause given in Part I.	1 X Yes	3 2 □ No 3 □ P	Day Year of the cause of death?		
					ed? death? IXNo 1 ☐ Yes	utopsy findings availa completion of cause s 2 No		
25. Was case referred to medical examiner?	Hospital:		Othor: (th (Check only one				
1 ☐ Yes 2 ☑ No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA 4 A Nursing H		nce 6 Other (Spenior occurred)	ecify)		
27. Manner of Death Matural 5 Pending Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No								
29a. Certifier (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)		
29b. Signature and title of confifier	e.ms		29c. License number	29	d. Date signed (Mon	th, Day, Year)		
30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, P	'rint)			-		
31. Date filed (Month, Day, Year)	154 N. ARTI:	CAN S	F. Williams	02T, M	D SI.	795		

Regis DHMH 17 Rev 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nor 2 Date of Death **Physician** Day AM NICHOLAS BARNAJ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Laurel Regional Medical Center Laurel Prince George's Social Security Number 6. Sex 7. Age (In vrs. last birthday) Under 1 Year If Under 24 Hrs. **Funeral** Date of Birth (Month, Day) Birthplace (State or Foreign Country) 1 🖾 M 2 🗆 F Months Days Hours Min Year Director 282-28-9101 85 Feb. 14, Ukraine 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9518 Flower Avenue 20901 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🛛 No Caucasian 3 Widowed 4 Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Library Administrator Library of Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mykola Barnaj Anastasia Barnaj ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Barnaj/Stepson 1937 Cradock Street, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of penetery crematory or other place)
Saint Andrew Ukrainian 01/1
Orthodox Cemetery 2010 20c. Location - City or Town, State South Bound Brooks, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 🖾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Jersey 1570 22. Name and Address of FacilityHINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tell re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Left Lung Collapse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2**X**No Other: 4 \sum Nursing Home Certification: To 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 💆 Natural 5 Pendina investigation 1 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Funeral Director: Affer this contractor.

To the Funeral Director: Affer this contractor. Il Director: /

> State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Tsion Berhane, MD,

14

and manner stated.

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

7300 Van Dusen Road, Laurel, Maryland 20707

2065

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18, Stephen Anthony Brown 2010 10:12 January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 400 Walnut Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1**X** M 2□ F 214-82-8295 48 <u> 10/01/1961</u> Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 □ No Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 400 Walnut Street 21502 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 197 If Yes, Give Year or Dates: 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 X Never Married 2 ☐ Married 1979 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White 1983 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 None Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel William Brown Eva Elizabeth Fraley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley A. Brown / Brother 305 Helen Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Cumberland Crematory: 01/20/2010 4 Donation Cumberland, MD of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 21. Signeture 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schenuc disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

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Health a

permit. Pages Department of Important: If it any Injury or c

Director

Funeral

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Be Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending pl signed by the a certificate has been s ector, page 2 should

Hospital or Attending Physician: The law requires that the death certificate be executed : After this certifica s funeral director, p n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu

Division of Vital Records, P.O. Box 68760,

within 2 To the I IUA nds State

completely

lical Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Happ - Due to (or as a consequence of):	
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Completed by Physician/Medical	Part II. Other significant conditions co Suppose Charles Charles he part Alcourt Almus	intributing to death but not resulting in the underlying cause given in Part I. COPD THE C Severe MANN AGATC VERYING Pulmonang Hyperers	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	26. Place of Death (C	heck only one)
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 X Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No	Describe how injury occurred
Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
cal		vsiclan: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred a	

29c. License number

29d. Date signed (Month, Day, Year) January 18, 2010

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State Registrar	te of Marylar		rtment of F tificate of I			ene .№2010	0.2571
			Decedent's Name (First, Middle, Last)					2. Date of Death	2010	3. Time of Death
	Physicia	an	_	izabeth	В	ohrer		Month January	Day Year 14, 2010	7:35 P M
in	/Medic		4a. Facility Name (If not institution, give street a				Location of Death	January	4c. County of Deatl	
	Examin	er	13001 6th Avenue	,		Cress	aptown		Alle	gany
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign
	Director		218-60-0421 1□ M 21	₹ 58	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y 11/09/19	51 Mar	yland
			Usual Residence of Decedent							
	yland how at	. [10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-fs	cto	MD Allegany		Cu	mberland				1X1Yes 2□No
	h the)ire	10e. Street and Number			10f. Zip Code	1500	10g	J. Citizen of What Co USA	untry?
	th wil	al	517 Fectig Avenue	_			1502		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Its. "After Eveniner must be notified at	by Funeral Director	1 ☑ Never Married 2 ☐ Married If Y	s Decedent Ever in Uned Forces?]Yes 2 X No es, Give		Was Decedent of H fYes, specify Cuba 1 □Yes 2ឦNo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian, e, etc. White
00	hours ural'	q pe		ar or Dates:	16a Dece	dent's Usual Occup	ation	16	bb. Kind of Business/	
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d 2	e filed val Hygid		17. Father's Name (First, Middle, Last)		11001			e (First, Middle, Ma	iden Surname)	
Maryland 21215-0036	should be f nd Mental marked o imatic eve	To Be	Leslie Pre	ston	Bohr	er	Elizabe	th N	Mae	Davis
ary	should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Type. Pri	nt)					City or Town, State, 2	
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)re	of He		20a. Method of Disposition	I	Place of Dispo	sition (Name of natory or other plac		Date 20	Oc. Location - City or	Town, State
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₹	slcia certi recto	Be	examiner? 1 Yes 2 No	ll: 1 ☐ Inpatient 2 [T FR/Outpotio	nt all DOA Oth	ner:	ome E Pecider	Son 6 MOther (Sa	ister's Residence
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	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: C	: To the best of my k	nowledge, dea nation and/or i	th occurred at the to	ime, date and place opinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	as stated. e to the cause(s)
	To the I- within 24 To the F complete	Medical	one) a 29b. Signature and title of certifier	nd manner stated.		29c. Licen			d. Date signed (Mon	
	Verit To		29b. Signature and title of certifier **Mouseofliff**	2. M	n		055325		January	
	5				00.1.					
			30. Name and address of person who complet Wonsock Shin,		_{em 23a) (Type} 5 Bisho	p Walsh	Road, Cum	berland,	MD 21502	
	TILL Str	ate	31. Date filed (Month, Day, Year)	,		-				
	Regist		JAN 15 2010	62. Registrar's Sig	1. Dar	Person				

DHMH 17 Rev 1/2001

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			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
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	Funeral		5. Social Security Number 6. Sex 7	Age (In yrs, last bi	Months Dav		8. Date of Birth (Month, Day, Yea Dec 23,	9. Birthplac Country	oe (State or Foreign
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-	how		10a. State 10b. County	10c. City, Tow	on or Location Cumberlance		-	100	. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f s	ecto	MD Allegany		10f, Zip Code		10a.	Citizen of What Country	^
4	3a or 3	ä	10e. Street and Number 36 Hawthorne Avenue		701, ZIP 00d0	21502		USA	
1	within 72 hours alter death with the maryland ham "natural", or items 23a or 28a-f show w Medical Exaninet must be notified at	Funeral Director	11. Marital Status 12. Was Decede Armed Force	s?	13. Was Decedent o	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americar Black, White, etc	Indian,
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ylan	Menta Menta arked atic ev	To B	Claude Allen Luck					Corbin Luck	
Maryland	d 2 sho th and t7 is ma traum		19a. Informant's Name/Relationship (Type. Print) Charles Baker SO	1	b. Mailing Address (Stre 3718 Rafte	ersridge Driv	ve Midlot	ty or Town, State, 210 C hian Va	23113
e,	of Heal		20a. Method of Disposition	20b. Place o	of Disposition (Name of ery, crematory or other p	place)		. Location - City or Tow	
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ono	ding Ph h. After th funeral	tion	27. Manner of Death D⊠ Natural DE Natur	Day, Year)	Injury \	Vork? 1 □Yes 2 □No	200. 200	,,	
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Divi	le Hospital or Atten 124 hours after deat e Funeral Director: letely filled in by the		29a. Certifier (Check only one) Check only one) 29a. Certifying Physician: To the base and manner	est of my knowled	dge, death occurred at the and/or investigation, in r	ne time, date and place my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)
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Divis			29a. Certifier (Check only one) Certifying Physician: To the base and manner	est of my knowled sis of examination or stated.	and/or investigation, in r	rense number	urred at the time, date	and place, and due to	tne cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 15, 2010 Joseph A. Brown 9:10pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 579-34-3429 25, 1925 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show show 1 ☐ Yes 2X No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with "natural", or items 23a or adical Examiner must be r 15301 Walbrook Court #3A 20906 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Logistics CIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Pages 1 and 2 should be Carleton Brown Callie Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I (Daughter) 20125 Waterside Drive, Germantown, MD 20874 other Debra J. Brown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 1/20/2010 Rockville, Maryland
22. Name and Address of Facility DeVol Funeral Home
10 East Deer Park Drive 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wites Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Pulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Hypotension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0065505

State Registrar

DHMH 17 Rev 1/2001

ΙÒ

MEDICAL CENTER DR, ROCKVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32 Registrar's Signature

CHENGI

FANG

31. Date filed (Month, Day, Year) JAN 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02577 State of Maryland / Department of Health and Mental Hygien [] Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Loretta Clara Barcheski January 14, 2010 11:55P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-22-3569 1 □ M 2 🂢 F JUIY2**2°, 19**23 86 Washington, DC **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Prince George's Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road, ET2218 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No White Specify: Be Completed by Specify: 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene.
27 Is marked other than "I rraumatic event, The Med Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Eugene Solomon Clara Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trains 20 Eucalyptus Knoll, Mill Valley, CA 94941 Pat A. LaRocca -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 1/23/2010 SilverSpring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, PA
4400 Powder Mill Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2 ☑No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1-18-10 D0069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Av., Suite 203, Ballinine MD 21209 NAQUI. 2835 Smitu 3. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 19 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland		riment of tificate of			eg. No. 2 A A	02578
	Physici	an	1. Decedent's Name (First, Middle, Last) Loretta Mae Bu	sh				2. Date of Deal	13 ^{Day} 10 ^{Ye ar}	3. Time of Death 22:30 M
-	/Medio		4a. Facility Name (If not institution, give s		-	4b. City, Town,	or Location of Deat		4c. County of Deat	
and the	LAGIIIII		Washington Adve				a Park	0.00	Montgom	ery Co thplace (State or Foreign
	Funeral Director		5. Social Security Number 5.77-46-5169 1□ Usual Residence of Decedent	7. Age (In yrs. Ia 73	Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day) 03/02	(Year) Co	hington, DC
	Maryland I-f show	tor	10a. State 10b. County DC	10c. City	Town or Loc Wa	shingt	on			10d. Inside City Limits 1 ⊠ Yes 2 ☐ No
	th with the 23a or 28s	Funeral Director	10e. Street and Number 1729 1st Street	SW		10f. Zip Code 20032			USA	ountry?
980	12 should be filed within 72 hours after death with the Maryland hand Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mackel Evanding must be retified at	þ	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cul ☐Yes 2XNo	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: b1	e, etc.
Maryland 21215-0036	72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade	ation com <i>pleted)</i>	16a. Deced	lent's Usual Occu	upation e during most of wo ed)	rking	16b. Kind of Business	/Industry
121	filed within Hygiene. other than '	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	ea)		Domestic	
pd 2	e filed al Hyg other vent, I	Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Na	me (First, Middle,	Maiden Surname)	
ylaı	should be fand Mental s marked o	10	Douglas Currie					Mae Bu		T- 0-4-)
Mar	d 2 sho lth and 27 is ma traums		19a. Informant's Name/Relationship (Type Patricia Bush/d						r, City or Town, State, MD 2078	
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pl	ace of Dispos emetery, crem	sition (Name of natory or other pl	ace)	Date	20c. Location - City or	Town, State
altim	# E # .		4 □ Donation 5 □ Other (Specify) 21 Signature of Fune at S	Lii	22	. Name and Add		<u> </u>		Street NE
ä	Depa Impo any Ir		23a. Part 1 Enter the disease, or complication or heart failure. List only on	ury					1 Wash Do	20002 Approximate Interval Between
68760,	Physician / Medical be executed by hysician and bhysician and step physician the prival-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Figure that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	nuo c ieno of):	othy	isease			Onset and Death
O. Box	ath cert attending for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1	death 3	Ectopic pregnal			23d. Date of de Month	elivery Day Year
σ.	w requires that the destable signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the ur	nderlying cause g	given in Part I.		obacco use contribute f	o the cause of death?
of Vital Records		Completed			_			24a. Was a autop perfor 1 □Yes	sy prior to death?	utopsy findings available completion of cause of
Vita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			thor:	ath (Check only o		
	ing Phys After this uneral dir	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatien 28b. Time of Injury	28c. Inj	4 🗆 Nursing		dence 6 □ Other (Sp now injury occurred	ecify)
Division	pital or Attendous after deatheral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (S City or Tou	Street and Number or F vn, State)	Rural Route Number,
_	e Hospital 24 hours a Funeral letely filled	edical C	29a. Certifier (Check only one) 29a Certifying Physical Examination (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the vestigation, in my	e time, date and place y opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
	To the Hosp within 24 ho To the Fune completely f	Mec	29b. Signature and title of certifier	and market stated			nse number		29d. Date signed (Mor	
			Seema	MD		D	68049		01/14/20	010
R	6		30. Name and address of person who co SEEMA SHARM	74 7600 C	ARRO	Print) LL AVE	, TAKO	MA PA	IRK, ME	20912
	Sta Regista		31. Date filed (Month, Day, Year) 2010	32. Registrar's Signa	ture	,				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For Sta	te of Maryland / Dep	ertificate of De		ientai Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	runcate of De	eatri	Reg	g. No. 201	3 lime of leath
	Physicia	n/	Margaret Mine	rva Brown			January	Day Year	4:40 PM
	Medic Examin		4a. Facility Name (if not institution, give street ar		4b. City, Town, or L	ocation of Death	CONTO - 1	4c. County of Dear	
			Doctor's Community			anham			George's
	Funeral Director	L	5. Social Security Number 5/9-18-2003 6. Sex 1 \square M 2	X F 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug • 29	(ear) 9. Bir 0,1911 V	thplace (State or Foreign untry) irginia
	nd ihow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
	Aaryla 8a-f s tified	Director	DC		Was1	hington			1 🔀 Yes 2 □ No
	the Na or 2		10e. Street and Number	-	10f. Zip Code		10	g. Citizen of What Co	
	th with ns 23 must	Funeral	1006 47th Street		2001		wife Voc or No	United	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. led Forces? Yes 2 X No ss, Give r or Dates.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit Specify: B1.	e, etc.
2-0	2 hour	plet	15. Decedent's Education (Specify only highest grade com	oleted) (Give	edent's Usual Occupat kind of work done du		ing 1	6b. Kind of Business	Industry
121	ithin 7 ene. • than	Completed	Elementary/Seconday (0-12) Col	ege (1-4 or 5+)	DO NOT use retired) Cook	ζ		Pri	vate
1d 2	iled w Il Hygi othel vent, 1	a B	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Ma	iden Surname)	
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Jan	should be file h and Mental H 7 is marked o rraumatic eve		19a. Informant's Name/Relationship (Type, Prin		ling Address (Street an				
e,	and 2		Charles Brown, Sr./	20b. Place of Disp	06 47th St			Oc. Location - City or	20019 Town. State
πor	age 1 ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State cemetery, cre	ematory or other place, s Cremator	Janua	ry 25,	-	Maryland
Baltimore, Maryland 21215-0036	permit. P Departm Importal any injur		21. Skinature of Funeral Service Lice is		22. Name and Address	of Facility St	ewart Fu	neral Home	e, Inc.
	40=60		23a. Patt . Enter the disease, or complications	s that caused the death. Do not en				ington, DO	Approximate
	Physician/		shock, or heart failure. List only one cause	e on each line.			_ '		Interval Between Onset and Death
	Medical		disease or condition resulting in death)	BACTED Oue to (or as a consequence of):		-			
-control	Examiner	<u>.</u>	Sequentially list conditions	DEMENT	10				
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	cate be executed physician and s the burial-transit	Еха	that initiated events C. ——	PEPTIC Due to (or as a consequence of): DECMBIT	VIC				
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876	tificate ng phy	Med	IF FEMALE:	<u> </u>					
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity.		23b. Was decedent pregnant in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	elivery Day Year
P.O.	that the ned by t detack	by Ph	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
ds,	v requires that been signed be should be det						1 🗆 Yes	s 2 □ No 3 □ F	Probably 4 Unknown
Division of Vital Records, P.O.	has bei	Completed					24a. Was an autopsy perform	prior to death?	
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VII:	ysicia is cert direct	To Be	examiner? 1 Yes 2 No Hospita	1 Lapatient 2 ER/Outpati	ent 3 DOA Other	r: 4 Nursing Ho	ome 5 🗆 Resider	ice 6 🗆 Other (Spe	cify)
ō	iding Physician: T th. After this certifica funeral director, p		27. Manner ath 28a 1 atural 5 Pending	Date of injury 28b. Time (Month, Day, Year) 28b. Time injury	work?)	28d. Describe how	injury occurred	
ion	ttendi death. tor: A the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	. Place of Injury - At home, farm, s		Yes 2 □ No	29f Location /Stre	eet and Number or Ri	ural Route Number
ivis	or Atteno after deat Director:		4 Homicide determined	building, etc. (Specify)	treet, factory, office		City or Town,		arai Houte Nambei,
	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or inve	estigation, in my opinior	n, death occurred a	t the time, date and	place, and due to the	cause(s) and manner stated.
	ithin 2 o the I	Me	only one) 3 Certifying Nurse Pract 29b. Signature and title of certifier	ioner: To the best of my knowledge	e, death occurred at the 29c. License			ause(s) and manner a d. Date signed (Mon	
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	1		30. Name and address of person who complete	ed cause of death (Item 23a) (Type	, Print)			,	20770
2	1 4		Cecil Donald Georg	e 7500 Hanove	a larkwa	y duite	101A 47	reen bett,	Mary/and
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2010	ed cause of death (Item 23a) (Type, 2500 HONOVE) 32. Registraris Signature	/				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12010 Year **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 6 artsville If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 422826 Months Days Hours 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examits or must be indifficial. 1 Yes 2 No TSVILLE Director 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working Life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8MESTIC 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be AllaWAY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) BOWIE MD. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Roanoke, VA 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 420 HST. NE. WASH., DC.ZOO Sign turn of Funeral Service Licensee OMR Approximate Interval Between Onset and Death Enter the disease, or complications that cau, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying. such as cardiac or respiratory arrest Immediate Cause (Final WKS. Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician a page 2 should be detached for use as the burial-P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ZNo 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 TYes 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of sertifier 29c. License number

CR 5

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 2010

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32. Registrar's Gigmatur

ss of person who completed cause of death (Item 23a) (Type, Print)

GOUTHERS bur 6, m.D. 20878

#ST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ORIGINAL

Physician /Medical Examiner and Division of Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific

To the Hospital of within 24 hours at To the Funeral D NJL

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of pation was completed case of death (ftern Aa) (Type, Print)

32. Registrar's Signatur

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LEVON BARGERON D. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 15 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 10, **Funeral** Social Security Numbe Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 🔀 F Kentucky **Director** 213-26-6882 78 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Crisfield Maryland Somerset 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4760 Jacksonville Road 21817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hayes R. Davis Opal M. Niece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2620 Felter Lane - Bowie, MD 20715 <u>Michael R. B</u>argeron (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Crematory of Delmarya 4 Donation 5 Other (Specify) 1/18/2010 Delmar, Delaware 21. Signature of Funer & Service Licensee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Mary Both Bridge Street - Crisfield, MD 21817 306 W. Main 23a. Part 1. Énter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate, Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, it any, tacking to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a confection of signed by the attending physician and defeached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? Director: After this certificate has autopsy perform Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\mathbb{Z} \) Other (Specify) \(\mathbb{Hospice} \) ျှ 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director. A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, D 29505 01-17-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO M. D. 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State

Registrar

JAN 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18^y 12:55 P M Nathan Otis Bridges January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ·A(a)a Civiste Charles 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 □ F Davs Hours Country) Director 415-50-3856 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Charles Waldorf 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2413 Pimpernel Drive 20603 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Training Manager Air National Guard 1 and 2 should be filed w of Health and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milford Otis Bridges Ada Heatherly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Bridges/ Wife 2413 Pimpernel Dr. Waldorf, Maryland 20603 Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State per nit. Page 1 a De artment of h Important: If ite any injury or ot 4 Donation 5 Other (Specify) Atlantic Crematory Jan_20, 2010 Glen Bernie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complia Approximate Interval Between Onset and Death shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner course Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation Division of Vital Records, Hospital or Attending Physician: The law requires 1 🗋 Yes 2 No 3 Probably 4 Unknown cate has been signated page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an AOMIC CLARACTES SIP New perform certificate COCHOXIO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2XNo မ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

State

OLD CINE CENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-00416	
Lovicie Ann Blackwe	ell
	1-
	Re
Physician/	١.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Ce	rtificate of	Death		F	Reg. No. ZUI	0 07203
Phys		n/	Decedent's Name (First, Middle,Las					Date of Dea Month		3. Time of Death 1532 hrs
edical Exa	amur	1er	LOVICIE ANN 4a. Facility Name (if not institution, give	BLACKWELL		b. City, Town, o	r Location of D	Month January 1	4c. County of	
			Civista Medical Center	e street and number)		La Plata	, cooding (or D	-	Charles	Dod.
Fune	ral		5. Social Security Number 6. Sec	ex 7. Age (In yrs.	last birthday)	If Under 1 Ye				9. Birthplace (State or
Direc	tor		156-28-9479	M 2 F 74	Yrs.	Months Da	ys Hours	Min. JUL.	7, 1935	Foreign VIRGINIA Country)
		ļ	Usual Residence of Decedent							
į.			10a. State 10b. County		, Town or Location	on				10d. Inside City Limits 1 Yes 2 X No
/land	once,	힏	VA WORTHUMBE	RLAND	GESS	406 75-0-4-			10g. Citizen of Wha	
the Maryland	notified at once.		10e. Street and Number 13454 NORTHUMBERLA	AND HIGHWAY		10f. Zip Code 22432			$U \cdot S \cdot A$.	i Country?
ı with	be no	uneral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?				(Specify Yes or Netro Rican, etc.)	o- 14. Race - White,	American Indian, Black, etc.
r deatl	must	뒤	1 Never Married 2 X Married	1 Yes 2 X No				,		BLACK
rs afte	miner	百	Widowed 4 Divorced Decedent's Education (Specify of	If Yes, Give Year or Dates: nly highest grade completed)		Yes 2 X No		l of work done	Specify: 16b. Kind of Busi	ness/Industry
2 hou	Exa	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life				,
036 ithin 7	fedica	Completed	11	2	DATA EN	TRY OPE				TURE EQUIP.
215-0036 be filed within 7 ntal Hygiene.	nt, the N	Be Co	17. Father's Name (First, Middle, Last DAVID COLEMAN	1			18.Mother's N ELSTE	ame (First, Middle, SCOTT	Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiera, Maryland, and the state of the state	matic eve		19a. Informant's Name/Relationship (1 WARREN C. BLACKWET	ype, Print) L (HUSBAND)	19b. Mailing 13454	Address (Stre NORTHUM	et and Number BERLAND	or Rural Route Nu HWY BUR	mber, City or Town,	State Zip Code) 22432
e, F I and Health	r tra	Ī	20a Method of Disposition 1 X Burial 2 Cremation 3		Place of Disposi crematory or oth		emetery,	Date	20c. Location - 0	City or Town, State
MOI Pages vent of	l de	-	1 A Burial 2 Cremation 3 4 Donation 5 Other Specify	FT1	RST BAP.		'RY 1	/23/2010	HEATHSV	$ILLE_{\rho}$ VA
Baltimore, permit. Pages I ar Department of Hee	injury	Ī	21. Signature of Funeral Service Licer					NERAL HOL		2502
Physici	ian	┪	23a. Part I. Enter the disease, or comp failure. List only one cause on ea						rest, shock, or hear	
/Medi Examir				Multiple Blunt Force Inj			· · · · · · · · · · · · · · · · · · ·			Death
			Sequentially list conditions, b.							
		iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	of):					
70	ısit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
760, cate be executed	the burial - transit		d. UNPENDED	AMENDED						
760, icate be	the buri		IF FEMALE:	23c. If yes, outcome of preg	gnancy				23d. Date of d	elivery
687 ertific	e as the	ician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of de	ooth		Ectopic pre	egnancy	Month ·	Day Year
Box 68 e death certif	for use as t	'55 I	1 Yes 2 No 9 Unknown	7	eath 5 Oth	er (Specify)				•
at the c	detached for	Phy	Part II. Other significant conditions	contributing to death but not i	resulting in the ur	nderlying cause	given in Part I.	23e, Did t	obacco use contrib	ute to the cause of death?
, P.O.	director, page 2 should be detach	g P						1 Ye	s 2 🗸 No 3	Probably 4 Unknown
rds requi	should	leted						24a. Was auto		ere autopsy findings available or to completion of cause of
eco he lav	age 2	dmo			•			perfo 1 ✓ Yes		ath? ✔ Yes 2 No
Z	tor, p		25. Was case referred to medical			26.Plac	e of Death (Ch	eck only one)		
Vita hysici	d direc		examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient			ursing Home 5		Other:
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.	r. Outel u	cation:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Jan 14, 2010	28b. Time of In 1457 hrs		ury at Work? Yes 2 ✔ No	Subject stri	how injury occurred uck by object th	nat fell off truck
ivisior	filled in by the	fical	2 Accident Investigati 3 Suicide 6 Could not	28e Place of Injury - At h	nome, farm, stree	t, factory, office	building, etc.			or Rural Route Number, City
Division of the safe	illed i	ertifi	4 Homicide determine		ad / Highway			Us Rt. 301 /	State) Northbound, , MD)
Division To the Hospital or Attenwithin 24 hours alter death	completely	edical C	TOTHECK OTHY	ian: To the best of my knowled r: On the basis of examination a	-					
To the within	сош	Medi	2 Medical Examine 29b. Signature and title of certifier	and manner stated			se number			i (Month, Day, Year)
			MILC	^			.M.E.		January 15,	
6			30. Name and address of person who	completed cause of death (Iter	n 23a)					
11/11	\ I	- 1						MD 04004		
CY/Y	\cup		Russell Alexander MD.	Assistant Medical Exar	miner 111	Penn Street	t, Baltimore	, MD 21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BrYANT 2010 DIANNE /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner Queer entre VIII 4nnes, INC uzen 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Year) Days Hours 1 M 2 F 218-58-1051 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Hean 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at any fujury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director stertown 10e. Street and Number 10g. Citizen of What Country? 21626 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cken Oner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bryant reeman 19a. Informant's Name/Relationship (Type. Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chalfont 4712 Virginia Beach Konald 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■Burial 2 □Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 113/20/0 21. Signature of Funeral Service Licensee Bennie Snith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Right Breast Concerto Boxe and Liven **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown signed by the at d be detached fo 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 2 **III** No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Ito Sm Ce ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Funeral Director: After of completely filled in by the funera al or Attending F 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours al 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 23889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 1/2 Street CHaster town John VX 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	epartment of Heal Certificate of Deal		, ,	0010	02597
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Deal		2. Date of Death	3. No./	U 2 J 0 1
	Physicia		_			Month	Day Year	3. Time of Death
	Medic		Edith Lantz Be 4a. Facility Name (if not institution, give street and number)	nt on 4b. City, Town, or Locat		anuary l		10.42 P
	Examin	er	342 Cypress St.	Millingto			4c. County of Dea Kent	tn
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda			8. Date of Birth		thplace (State or Foreign
	Director		218-01-0154 1 M 2X F 91 Yrs	s. Months Days Hou		(Month, Day, Ye 8/4/1918	ear) Co	untry) MD
	W		Usual Residence of Decedent					
	/land f sho ed at	ţ	10a. State 10b. County 10c. City, Town or	r Location				10d. Inside City Limits
	Mar 28a- otifis	ire		ke Village				1 ☐ Yes 2 🛣 No
	th the	alD	10e. Street and Number	10f. Zip Code		109	g. Citizen of What Co	ountry?
	th wit	Funeral Director	30897 Overfall Dr.	91362			USA	
	r iter		Armed Forces?	 Was Decedent of Hispanion If Yes, specify Cuban, Mex 	ic Origin? (Speci exican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
936	al", o	q p	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates.	1 ☐ Yes 2 🖾 No Spe	ecify:		Specify: Wh	ite
9	hours natur ical E	Completed by	15. Decedent's Education 16a. De	ecedent's Usual Occupation		16	6b. Kind of Business	
215	n 72 an "r	g .		Aive kind of work done during ie. DO NOT use retired)	most of working			
21	withi giene er th , the	ပိ		cretary			Hardware	Retail
nd	filed al Hy d oth	Be c	17. Father's Name (First, Middle, Last)	18. N	Mother's Name	(First, Middle, Mai	iden Surname)	
<u>X</u>	ld be Ment arke	₽ P	Nathaniel Samuel Bramble	M	lary Ali	ce Baile	y	
lar	shou and is m	33		Mailing Address (Street and Nu		<i>*</i>		
~	ind 2 lealth m 27 her to			49 Casson Nec	k Rd. C	ambridge	, MD 2161	3
ore	t of H If ite or otl		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	isposition (Name of crematory or other place)	Da	ate 20	c. Location - City or	Town, State
턡	t. Pag tmen tant; ijury			ake Cremation			Stevensvil	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	A	21. Signature of Funeral Service Licensee	22. Name and Address of F Fellows, Hel 370 W. Cypre	Facility Lfenbein ess St.	& Newna Millingt	m Funeral	Home 651
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one or death line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	otic Vas	S Cn (Ar	1		Approximate Interval Between Onset and Death
09	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence oi). C. Due to (or as a consequence of): d.					
. Box 687	ath certific attending for use as	/We		3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	livery Day Year
ls, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in I	Part I.	23e. Did tobac	\	the cause of death?
Division of Vital Records,	I or Attending Physician: The law req after death. Director: After this certificate has bee I in by the funeral director, page 2 shou	Completed				24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
a F	an: T rtifica tor, p	Bec	25. Was case referred to medical	26. Place of	f Death (Check o		No 1 ☐ Yes	s 2 No
Ĭ	ysici is cer direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4	☐ Nursing Hom	e 5 🗆 Residend	e 6 🕅 Other (Spec	Home of
o	ig Ph ter th		27. Manner of De th 28a. Date of injury (Month, Day, Year) injur	e of 28c. Injury at		d. Describe how		
on	vttendir death. ctor: Af y the fu	fica	2 Accident Investigation	M 1 Yes	2 🗆 No			
VISI	I or Attu after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	28	3f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
۵	ital ours at ral D							
	Hosp 24 ho Fune sted fi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	nvestigation, in my opinion, dea	ath occurred at th	ne time, date and p	lace, and due to the	cause(s) and manner stated.
	To the Hospital or v within 24 hours after To the Funeral Dire completed filled in b	Ž	only one) 3 Certifying Nurse Practioners on the best of my knowledge 29b. Signature and title of certifier	ge, death occurred at the time, 29c. License numb			use(s) and manner as . Date signed Monti	
			1 2/1 (2)	D//	400	, 290	Date signed (Monti	1, Day, Teal)
	12		30 Name and address of person who completed cause of death (Item 23a) (Typ	9 2/6	1 1		1/13	1,0
	M 5		Wayne Disenjamin M.	D. Ches	Fer to	man,	Mil	21620
	Stat Registra		31. Date filed (Month, Day, Year) JAN 2 0 2010 32. Registrar's Signature	harles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 600 M JANUAR 2010 Christine Bitting Baer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** ALBO MEMORIAL HOSPITAL EASTON EASTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√2 F Pennsylvania Director 79 Oct 18, 1930 204-22-3981 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show ed at r 28a-f sh notified 1 ☐ Yes 2 ☐ No Director Queen Annes Centreville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1740 Church Hill Rd. 21617 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes ANO If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ▼No Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Pages 1 and 2 should be nent of Health and Mental Laura Katherine Byrkett William Richard Bitting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Hockessin, DE 19707 Ann Moore Daughter P.O. Box 1451 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/15/10 Carroll Cremation Inc | Hampstead, Maryland 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA 21. Signare of uneral Service Licensee 412 Washington Rd. Westminster, MD 21157 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and strans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Dav Year 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 No Nown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the I within 2. and manner stated. 29c. License number 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) 2010 51 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

JAN 1

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Registrar
DHMH 17 Rev 1/2001

BAE

a 249 Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Box 26 per Phy. 01/19/2010 Carroll County, will
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 17, 8:25 p Jane Virginia Bair January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Westminster 201 Warfieldsburg Rd. WES CITE TO THE STATE OF BIRTH Months Days Hours Min. Nov 26, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1952 1 □ M 2 🗷 F Maryland 57 Director 218-52-2647 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2X No Director Westminster MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21157 USA 201 Warfieldsburg Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married & Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Building and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Leasing, Inc. 12 Secretary/Treasurer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Gist ပ Farl Bertram Henry 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. Westminster, MD 201 Warfieldsburg Rd. Emerson F. Bair Husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 1/22/2010 Smallwood, Maryland Deer Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of uneral Service Licensee 412 Washington Rd. Westminster, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMPRYSEMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** OBSTRUCTIVE PULMONARY - HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed KIGHT KEART Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □ Yes 2,200 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No eral Director: A filled in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D42827 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 826 WASHINGTON PD, JUITE 130 WESTMINSTER, MJ 21157 , mil MICHARL CAUSING 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN19

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 24a per phys. G900 2/25/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010^{Year} 8, Merle G. Barnes January 6:58pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Westminster Carroll | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. | Min. | March 14, 1 Social Security Number 6. Sex 9. Birthplace (State or Foreign Country)
PA 7. Age (In yrs. last birthday) Funeral 1 MM 2 □ F 72 Director 210-28-2737 1937Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be redified at Director MD 1 □Yes 妆 □ No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 810 Dutchess Drive 21784 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Inc. Once. 10 Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanlev Barnes Sylvia Wigfield ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jane E. Barnes (Spouse) 810 Dutchess Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 1/13/2010 Artemas, PA 21. Signature of Funeral Service Licensee MOOK4 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of the line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 1 □ Yes 2 **X**No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 □ Yes 2 No To the Hospital or Attenwithin 24 hours after deatl filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signatur 29d. Date signed (Month, Day, Year) d title of certifier WIL

Registrar DHMH 17 Rev 1/2001

State

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address of person who

JAN 14

31. Date filed (Month. Day, Year)

WESTMINSTER, MD 21157

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sutt (ato.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010° James Glenn Barker January 20, 7:40 P.M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Washington 15715 Fenton Ave. Williamsport 8. Date of Birth (Month, Day, NOV • 2, 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours ^{Year)} 1930 Months XXM 2□ F 233-46-7990 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XYes 2 ☐ No Maryland Williamsport Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15715 Fenton Ave. 21795 IISA 12. Was Decedent Ever in U.S. Atmed Forces? 18 Was 2 | No 1948 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Leather Processing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barker Lillie F. Madden Zachariah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williamsport, MD 21795 Wava A. Barker - Wife 15715 Fenton Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Smithsburg Crematory 01-24-2010 | Smithsburg, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or conditior resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Но 1 Yes 2 10 er (Specify)

Physician /Medical Examiner

Department of Health a Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Mexical Experiment must be rediffed at

Baltimore, Maryland 21215-0036

Examine signed by the attending physician and is be detached for use as the burial-transit Physician/Medical 2 I or Attending Physician: The law requir after death. Director: After this certificate has been si J in by the funeral director, page 2 should I Completed Be Certification:

Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

spital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 DC	Other: 4	☐ Nursing H	ome	5 XX esidence	6 ☐Other
28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M 2	8c. Injury at Work?	2 □No	28d.	Describe how inj	ury occurred

27. Manner of Death Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide

29a. Certifier Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifile

M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> 1130 Opal Court Hagerstown, MD 21742

34-4+1 State

To the Hospital of within 24 hours a To the Funeral D

31. Date filed (Month

Hind Hamdan M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

filled in by

completely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Jan. 16, 2010 **Physician** 0637 B. Corona Juana /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Shady Grove Adventist Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 / 29 / 1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. 1 □ M 2 🙀 F 579-70-2238 89 Cuba Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Montgomery Village 1 TYYes 2 □ No MD Montgomery Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 and 1 items 23a or 2 and 2 20886 USA 19301 Watkins Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 XYes 2 □ No Specify: Cuban White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Insurance Company 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanca Rodriquez Juan Ramos ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Martha C. Prats/Daughter 15913 Willis Way Woodbine, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Agmoval from State Gate of Heaven 1/19/2010 Silver Spring, Md 4 □ Donation 5 □ Other (Speg 21. Signature of Funeral Service Li PHILIPADE RIVALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the onse se, or complications that caused the shock, or heart in lure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary artery disease /Medical Due to (or as a consequence of) Examiner Congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Hypertension Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) sate has been signed by the a page 2 should be detached to 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown Be Completed pacemaker for complete heart block, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paraplesia autopsy performed spinal stenosis
25. Was case referred to medical examiner? 2 No 2 No 1 Tyes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending death. 1 ☐Yes 2 ☐No ours after death.

Neral Director: A investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

To the within 2

Baltimore, Maryland 21215-0036

68760.

Box (

P.O.

Records,

Division of Vital

19529 Doctor's Drive Germantown, Md. 20874 V.Ganti M.D. 31. Date filed (Month, Day, Year) JAN 19 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J

29c. License number

D41162

29d. Date signed (Month, Day, Year)

Jan. 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2010 9:05 p 16, Francis Matthew Cauley, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 16540 Emory Lane USA Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 313-20-9663 Months Days Hours Min Jan Month Day, Year 27 13 M 2 D F Indiana Director Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 🗆 Yes 2 🏲 No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? Funeral 16540 Emory Lane 20853 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 XYes 2 ☐ No If Yes, Give 1 9 72 hours after Baltimore, Maryland 21215-0036 rr Yes, Give 1945–46 Year or Dates. 1 ☐ Yes 2 ☐ No Specify: Specify: White "natural", 3 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Director of Operations Electronics/Defense traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Francis Matthew Cauley, Sr. Katherine Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Rhodes Cauley/Wife 16540 Emory Lane, Rockville, MD 20853 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔼 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery Jan. 2010 4 Donation 5 Other (Specify) Crownsville, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Signature of Funeral Service Licensee Inc. Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cirrhosis Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami -transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached the 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be Records, Diabetes, Hypertension 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

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Kuestop

Year)

2010

Christopher Mays, MD

31. Date filed (Month, Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D39793

18111 Prince Philip Drive, Olney, MD 20832

January 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra MEND#23a +28bperME, 1/22/10, BMW.McCocertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0005AM Medical 01 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ressitu Balhmore pilas 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** last hirthday If Under 1 🔀 M 2 🗆 F Months Davs Hours Min. 1 1 7 0 6 7 1 9 6 9 699-78-7462 Director Mavi Usual Residence of Decedent or 28a-f show e notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Laurel 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral 23a 20707 Mexico 16112 Malcol Drive items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No ò Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Mexican If Yes, Give Specify: White "natural", 3 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Electric Company Electrician a and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maria Del Carmen Andrade Pena Department of Health and Ment.
Important: If item 27 is marked any injury or other them. Alberto Casas Cruz 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Del Carmen Casas/ 16112 Malcolm Drive Laurel, Maryland 20707 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven 1/13/2010 Silver Spring, Md central areas and a cardiac or respiratory arrest, and a cardiac or respiratory arrest or cardiac or respiratory arrest or cardiac or respiratory arrest or cardiac or car neral Service Lie 21. Signature PHILIP ACCESS TWALDI FUNERAL SERVICE, P.A. Columbia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury g physician and is the burial-trans that initiated events resulting in death) Last to (or as a consequence of) Physician/Medical P.O. Box 68760 ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown the 9 Unknown signed by the Part II. **Other significant conditjons** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy emia certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case re erred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No 29-09 death. Investigation unknown 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St. et and Number or Rural Route Number, filled in by after determined City or Town, State) LEEDS AVE, UNIVERZEAL SUZGICAL within 24 hours a To the Funeral C ASSOCIATES GALTIMORE, Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore

Registrar
DHMH 17 Rev 7/2009

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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanthar must be indiffed at once.	ř	19a. Informant's N		1. 1. 21							Route Numb				_ '
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	o the lithin 2 o the lomplet	Medical	one) 29b. Signature and	d title of certifier	and manner	stated.		4	29c. Licen	se number			29d. D	ate signe	d (Month,	Day, Year)
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	4		30. Name and add	lress of person	who completed cause o	f death (Ite	m 23a) (Type	e, Print)								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jan 2010 Ruth Coffman Р. Naomi 8:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5507 Cordona Street Lanham Prince Georges 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2/□ F washington, Director 80 578-38-1245 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1√2 Yes 2 ☐ No Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? þ er than "natural", or items 23a or the Medical Examiner must be Funeral 5507 Cordona Street 20706 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 K No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 8 Own Home age 1 and 2 should be filed went of Health and Mental Hygint: If item 27 is marked other yor other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Fenton Maude Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Coffman (Daughter) <u>5507 Cardona Street</u> Lanham. MD 20706 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 1 Durial Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 1/18/2010 Beltsville, MD 21. Signature Juneral Service Licenses 22. Name and Address of FacilityRendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ... Ectopic pregnancy in the past 12 menths?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 5 Other (specify) then signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has funeral director, page 2 autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 욘 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred After (Month, Day, Year) injury Natural 5 Pending Accident 2 No Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

Registrar

DHMH 17 Rev 7/2009

сопретер within 2.

Medical

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0023125

6502 Kenilworth Ave. #100 Riverdale, MD 20731

29d. Date signed (Month, Day, Year)

10

1

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10 CHANDERJEET 2010 KENNARD JANUary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince 6 corge's cheves 10 6-evers If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) Guyana 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Months 1946 Dec. 16, 578-72-9844 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10h Counts 10a State 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 □ Yes 2√ No Director MD Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1209 Patriot Lane 20716 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 TX Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify ģ 3 Widowed 4 Divorced Indian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Trucking Company Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Margaret Chanderjeet Mano Chanderjeet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowie, Md. 20716 1209 Patriot Lane Luvina Chanderjeet-Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 1-19-2010 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 21. Signature of Funeral Service Licensee 4308 Suitland Rd. Suitland, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosal eroTic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the a P.O. 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy 2. No 1∏Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ospital or Attending hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 2010 ÕŠ Woodrow Cunningham, Jr. Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bowie Health Center Prince George's Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🖾 M 2 🗆 F Months **Director** 61 1948 212-46-0453 Maryland Julv 8. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 □ No Prince George's Bowie Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 3702 Excalibur Court # 304 20716 <u>United States</u> within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes : If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. African American Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Musician Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Woodrow Cunningham, Sr. Beatrice Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Vickie L. Cunningham/ Spouse Excalibur Court, # 304 Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date January 16, 1 Burial 2 X Cremation 3 Removal from State Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2010 21. Si nature of Funer | Servi | Lic ns-e 42. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE 20019 Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shows or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Acute Cardiopulmonary Arrest
Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Gastroesophageal Reflux Disease that initiated events resulting in death) Last Due to (or as a consequence of) inding physician ause as the burial-/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l , page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\supseteq\) Other (Specify) 1 🗌 Yes 2 🛂 No ည 1 Inpatient 2 X ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) funeral (27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Division of Vital within 24 hours after oeau..

To the Funeral Director: After th 6

> State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

William S. Vaughn III M.D. 3060 Mitchellville Rd. Suite 211 Bowie, MD 20716 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D43641

City or Town, State)

29d. Date signed (Month, Day, Year)

January 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland		artment of H <i>tificate of l</i>			2010	0.2500
		1. Decedent's Name (First, Middle, Last)		TillCale Of L	Jean	2. Date of Deat	eg. No.	3. Time of Death
Physicia	n	Bobbie Jean Coppock				Month	Day Dio	Olics AM
/Medica		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		4c. County of Dea	
LAdilline	'	Prince George's Hospital Cente	r		Cheverly			e George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	rear) C	thplace (State or Foreign ountry)
Director	-	578-64-4493 12M 2LF 61 Usual Residence of Decedent	Yrs.			Feb. 20	1948	Georgia
aryland show			Town or Lo	cation				10d. Inside City Limits
Mary a-f sh	to	Maryland Prince George's		Cap	itol Hei	ghts		1 X Yes 2 No
th the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	ountry?
ath wi		6304 Foote Street		207			United S	
	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ★ No If Yes, Give		Was Decedent of H f Yes, specify Cuba 1 □Yes 2⊠No	ispanic Origin? (S an, Mexican, Puer Specity:	to Rican, etc.)	14. Race - Ame Black, Whit Specify: B	te, etc.
2 hours		3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business	/Industry
permit. Pages 1 and 2 should be filled within 72 Department of Health and Wental Hygiene. Important: If flem 27 is marked other than "n any Injury or other traumatic event, the Machana Conce.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1	life. L	Roof	1)	rking	Priva	te
il Hyg other	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, I	Maiden Surname)	
uld be Wenta Menta rrked	은	John Coppock				ie Parri		
2 sho and i is ma		19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State,	
t and tealth	1	Ruby Wanamaker/ Wife 20a. Method of Disposition 20b. Pl.					ights, Md.	
ages and of the right		1 △ Burial 2 ☐ Cremation 3 ☐ Hemoval from State	-	sition (Name of natory or other place	Juli	uary 19,	•	
nit. Parametarimet		4 □ Donation 5 □ Other (Specify) 21. Shouture of Funeral Service Liousian		Lincoln 2. Name and Addre		010 tewart Fu	neral Home	d, Maryland
Ped E ma		+ JOHN H. MIONOCH	4	001 Benn	ing Rd.	NE Washi	Ington, DC	20019
		23a. Pa t1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
Physician		Immediat Cause (Final disease or condition	صالعا	ar Car	none	,		Onset and Death
/Medical Examiner		resulting in death) Due to (or a a consequ						
	Į.	Sequentially list conditions, b. b.	ence of					
uted d ansit	Examiner	tan, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events cause in the control of the cause of the control of the cause of						
ficate be executed ficate be executed physician and s the burial-transit	Exa	resulting in death) Last Due to (or as a consequ	ence of):			,		
cate b	edical	d						
eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnal	ncv				23d. Date of de	elivery
death death d for u	slcian/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal} \) Fetal 4 \(\subseteq \text{Pregnant at time of details} \)	death 3	☐ Ectopic pregnand ☐ Other (specify) _	У		Month	Day Year
at the lby the stache	Phys	9 Unknown				on- Dida-	haana waa aantributa i	to the course of death?
quires that the de	Ď	Part II. Other significant conditions contributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
law requir	Completed					24a. Was a autop perfor	sy prior to	autopsy findings available completion of cause of
vital net						1 □Yes	2 🖾 No 1 □ Ye	s 2 No
siclar sectification	Be	25. Was case referred to medical examiner? 1	EB/Outpation	ot 3 🗆 DOA Oth	051	ath <i>(Check only or</i>	ne) ence 6 □Other <i>(Sp</i>	accifu)
oll Ol VICA nding Physician: th: After this certifica funeral director, is	i T	27. Manner of Death 1 🔼 Natural 5 □ Pending (Month, Day, Year)	28b. Time o Injury				ow injury occurred	cony)
tendir eath. or: Ai	catic	2 Accident investigation		M 1 🗆	Yes 2 □ No	001 1 112 10		Down Bouto Alumbar
al or At s after d il Direct	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		City or Tow	treet and Number or I n, State)	Hurai Houle Number,
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinal and manner stated.	wledge, deat tion and/or ir	th occurred at the tinvestigation, in my	me, date and pla- opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
3		Karen R Brooks	mi) D 60	4218	3	Jan 13, 2	010
912		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	RM	ovov11	mn	20785
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture	1/4.		100019		-,
Registra	ar	JAN 1 9 2010 Court 1.	March 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 01 Dorothy Clark 1635 Thomas Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Silver Spring Montgomery <u> Holy Cross Hospital</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🖾 F Hours 06/11/1924 Washington, Director 578-26-7697 DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No DC Washington 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 725 24th Street. NW Apt. 20032 items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Completed 3 Widowed 4 X Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) VA Administration 10 Clerical Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Pauline Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vondell V. Mayo - Niece Matthews Cove Drive Montross, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Lincoln Cemetery 01/21/2010 4 Donation 5 Other (Specify) Brentwood, MD 21. Signature of Funeral Şervice Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Montgomen 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Litter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Priysician/ End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Leukocytosis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \) Yes 2 \(\subseteq \) No Month Pregnant at time of death 5 Other (specify) detached 9 Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires Records, Failure to Thrive 1 Yes 2 No 3 Probably 4 K Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 K No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 🛛 Natural 5 Pending work's n 24 hours after death. e Funeral Director: Al pleted filled in by the fu 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 2 Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the pasis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hosp within 24 hosp within 24 hosp spaces and spaces and spaces are spaces and spaces and spaces are spaces are spaces and spaces are sp

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Purnima Joshi,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

Holy Cross Hospital 1500 Forest Glen Rd Silver Spring, MD 20910

D19563

29d. Date signed (Month, Day, Year)

01/16/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Ruth Conway Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS-RMC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day Year) MD 1928 Director 215-26-1603 81 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **Funeral Director** Allegany Rawlings MD 1 ☐ Yes 2 ☐XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17811 McMullen Highway 21557 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify. white Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Carrie Catherine (Toms) French James Riley French permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic any in. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 15709 Packard Drive SW Cumberland M MD 21502 Robert Sulser son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Sunset Memorial Park 1 XBurial 2 Cremation 3 Removal from State 1/29/201 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Fart . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STRUCTIVE DISEASIS Physician/ HRD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy To the Funeral Director. After this certificate has been signed by the attent of the Funeral Director. After this certificate has been signed by the attent of the Funeral director, page 2 should be detached for its in the past 12 months?
1 ☐ Yes 2 № No Month Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by OBSTRUCTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ၉ 1 🗌 Yes 2 **p** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D26907 Herdh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BISHOP WALSH ROAD CLYMPERLAND, MD 21503

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 2 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year DIAM **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner tow Ha lerwar If Under 1 Vear If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Min. Months Days 1 ☐ M 2 💢 F Washington, May 10. 1914 Director 95 579-09-3156 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Mount Airy Maryland Carroll death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21771 6130 Challedon Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Baltimore, Maryland 21215-0036 ģ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 9 Kemper Lee Mills, Sr. Beatrice Theole Mangum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trau 6130 Challedon Circle, Mount Airy, Maryland 21771 John E. Cady, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Other (Specify) Fort Lincoln Cemetery 1/19/2010 Brentwood, Maryland 4 Donation . Signature of Fune 22. Name and Address of Facility Molesworth-William Funeral Home 26401 Ridge Road, Damascus, Maryland P. 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cluse or learn line. Approximate Interval Between Onset and Death I mediate Caus dis ase or cond resul in do (Final **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💃 🗍 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 210 No ÀZ No 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital 20 No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 🔲 Inpatient Medical Certification: To After this funeral Manner of Death

Natural

Control 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 Homicide Hospital 12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10

MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02603 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1605 M Mary E. Christopher January 2810 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memoria Laston Hospital at Laston 8. Date of Birth May 17, 1916 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday, **Funeral** Min. 1 🗆 M 2 🔀 F Months Hours 93 219-01-8036 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director Easton Talbot 1X Yes 2 □ No MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ō Examiner must be 21601 23a Funeral 520 North Washington Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2XXMarried ☐ Yes 2 🗓 No "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Christopher, Mary Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Talbot Bd. of Education Food Preparation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Burton Venables Maude Lovica Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 N. Washington St., Easton, MD 21601 19a. Informant's Name/Relationship (Type, Print) Lloyd R. Christopher/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗆 Other (Specify) Sharptown, Maryland 01/22/10 Firemen's Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death n signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 20℃ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🕾 Natural 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

29d. Date signed (Month, Day, Year) 010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2010^{ear} Day 7:55 Ам Nila Kay Coleman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kent Chestertown 106 Cedar Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 屎 F Days Sept. 20, 1934 Maryland 75 Director 217-28-2824 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director Maryland Kent Chestertown 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 106 Cedar Street United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) County Government 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daisy Hadaway Lloyd Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Cedar Street, Chestertown, MD 21620 Harold Irving Coleman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan^{Date}10 1 😾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Chapel Cemetery 2010 Rock Hall, MD 2. Name and Address of Facility. ellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Funeral Service License Speer Road, Chestertown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC GASTRIC disease or condition nears Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes No 9 Unknown Year Month Day signed by the aid be detached for P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 No Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? 2 Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigating in more investigating in the cause of the c 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0041587 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

Registrar DHMH 17 Rev 7/2009

State

NOBLE

31. Date filed (Month, Day, Year)

EER RD CHESTERTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month Howard John Cox, Jr. .2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cecil Elkton Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Year) 2/5/1950 221-34-5144 59 Woodbury, Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Earleville Cecil MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21919 295 Pond Neck Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural", Specify Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Refinery 12th Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard John Cox, Sr. Anna M. DeLiberis permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 295 Pond Neck Road, Earleville, MD 21919 Patricia Cox/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial ** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2010 Newark, DE United Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St., Middletown, DE 19709 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line Immediate Cause (Final Myocardial Houte Physician/ Unknown Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death g Unknown Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director, it 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of Pertifier 29d. Date signed (Month, Day, Year) 10023322 Sachder-S. 1.19.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

11:23 MAN

1 🗌 Yes 2 🔀 No

Approximate Interval Between

Onset and Death

Day

Year

NJ

Registrar DHMH 17 Rev 7/2009

State

Elkan MD 21921.

For State Registrar

Howard

G. 31. Date filed (Month, Day, Year)

JAN 15

Lanham,

32. Fegistrar's Signature

Physician

/Medical

Examiner

Be Completed by Funeral Director

ို

Examiner

Physician/Medical

Medical Certification: To Be Completed by

Funeral

Director

For	State of Ma	ryland / L	Departme	ent of Health and	l Mental H	ygiene	!	
State Registrar		•	Certifica	ate of Death		Reg. No.	2010	1 02606
. Decedent's Name (First, Middle, Last,)				2. Date of D	eath Day	/ Year	3. Time of Death
Maude Myers	Corbin				Janua			
a. Facility Name (If not institution, give	street and number)			y, Town, or Location of Dea	ath	4c.	County of Dea	
Carroll Hospice D		//		Westminster Her 1 Year If Under 24 Hi	rs 9 Date of F	lieth	Carr	
213-05-3375	x 7. Age ☐ M 2 X F	(In yrs. last bir 98	Yrs. Month		n. Apr 1	Day, Year)	911 Ma	rthplace (State or Foreigi country) ryland
sual Residence of Decedent a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
Maryland Carrol	1			Westmins	ter			1 □ Yes 2 No
e. Street and Number 811 Rolling Ridge	Drive		10f. 2	Zip Code 2115	7	10g. Cit	izen of What C	country?
. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dec	cedent of Hispanic Origin?	(Specify Yes or I	No-	14. Race - Am	nerican Indian.
1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 ▼No If Yes, Give Year or Dates:		If Yes, s	pecify Cuban, Mexican, Pue	erto Rican, etc.)		Black, Whi	
15. Decedent's Edu (Specify only highest grad	cation	16a	(Give kind of s	sual Occupation work done during most of w	rorking	16b. Ki	nd of Business	s/Industry
Elementary/Secondary (0-12)	College (1-4or 5+	-)	Seams				Clothi	ng
. Father's Name (First, Middle, Last)					ame (First, Midd			
James R. Myers					rude E.			
9a. Informant's Name/Relationship (7) Carolyn Seabolt,			9	iss (Street and Number or ing Ridge Dr				
Da. Method of Disposition	daugnter	20b. Place o	f Disposition (A	lame of	Date		ocation - City o	
1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		cemete	ry, crematory o	r other place)	18/2010		•	ter, MD
1. Signature of Funeral Service Licens	ee			and Address of Facility llis Street,	Myers-Du Westmir	rbora ster	aw Fune , MD 21	ral Home 157
3a. Prt 1. Enter the disease, or compl nock, or heart failure. List only on nmediate Cause (Final	ications that caused ne cause on each line	Э.			iac or respiratory	arrest,		Approximate Interval Between Onset and Death
lisease or condition esulting in death)	Due to (or as a			ruent				J days
	h							
equentially list conditions, any, leading to immediate ause. Enter Underlying	Due to (or as a	consequence	of):					
ause (Disease or injury at initiated events	c							
sulting in death) Last	Due to (or as a	consequence	of):					
	d							
FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome of	⊇ ☐ Fetal déath	n 3 □ Ectopi 5 □ Other	c pregnancy (specify)		-	23d. Date of d Month	elivery Day Year
9 ☐ Unknown	9 Unknown							
art II. Other significant conditions co Dementia	ntributing to death bu	t not resulting i	n the underlying	g cause given in Part I.		d tobacco i		to the cause of death? Probably 4 Unknowl
					24a. Wa		24b. Were a	autopsy findings available
					- au pe 1 □ Yes	topsy rformed? 2/2/ No	death?	
5. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatier	nt 2 ER/O	utpatient 3□	Othor	eath <i>(Check onl</i> Home 5 ☐ Re		6 X Other (Sp	Hospice
. Manner of Death	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Injury at Work?	28d. Describ			
1 ☑ Natural 5 ☐ Pending investigation	(M	1 ☐ Yes 2 ☐ No				
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, fa . (Specify)	ırm, street, fact	ory, office	28f. Location City or 7	(Street ar own, State	nd Number or i	Rural Route Number,
		examination as		ed at the time, date and plate ion, in my opinion, death or				
9b. Signature and title of certifier	,			29c. License number		29d. Da	te signed (Moi	nth, Day, Year)
1/2 01	21-	1	4.5	D17040		Tan	lar, l	5, 2010
- Louis	Jane	zame	(M)		estmin			
80. Name and address of person who co	omplet∉d cause of de	ath (Item 23a)	(Type, Print)	WW	esimin	5 [[]	" [AII] >	TTD /

DHMH 17 Rev 1/2001

M.D. 215 Washington Heights Medical Center

Amended #2, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per fd, 01/26/10, State of Maryland / Department of Health and Mental Hygiene Allegany Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17-1109 Charles Nelson DeLong 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Cumberland Center WMHS Regional Medical 5, Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 07/31/1927 Country)
WEST VIRGINIA 1 🔀 M 2 □ F Months Days Hours Min Director 234-38-9458 Usual Residence of Deceden 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. it item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No ALLEGANY CUMBERLAND MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 13725 BEDFORD ROAD, N.E. 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black White, etc. 1 Never Married 2 Married à Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: 3 X Widowed 4 Divorced WHITE Completed WWII Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CELANESE FIBERS CORP. SPINNER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည THELMA GLADYS KUNKLE MARVIN JAMES DeLONG permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic of 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 GREENE STREET, CUMBERLAND, MD VALERIE DeLONG / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State RESTLAWN NEML.GARDENS: 01/20/2010 LAVALE, MD 4 Donation 5 XOther (Specify) ENTOMEMENT Funeral Service Name and Address of Facility
UPCHURCH FUNERAL HOME,
202 GREENE STREET, CUM 21. Signatur Approximate Interval Between Onset and Peath 23a. Part 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequer **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Yes 2 No g Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 1 Anpatient 2 ER/Outpatient 3 DOA ျ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural work? 5 Pending 2 🗌 No Investigation Accident ☐ Accider ☐ Suicide filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe · worsoch Shin D0055325 01/18/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road, Cumberland, MD 21502 Wonsock Shin, M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

JAN 20 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wayne Thomas Dixon Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Western MD Regional Medical Center Cumberland Allegany Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 - F Hours Months Days Country) Director 215-36-8724 69 08/21/1940 Maryland 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo MD Allegany Flintstone 1 Yes 2 No ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12412 Murleys Branch Road 21530 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian, Armed Forces Black, White, etc. 0 þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Heaith and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Elmer Dixon Amelia Jane Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine M. Dixon / Wife 12412 Murleys Branch Road, Flintstone, MD 21530 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glendale Cemetery 01/15/2010 Flintstone, MD 21. Signature of Funeral Service 22. Name and Address of Facility dams Family Funeral Home, P.A. any 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or iinjury Typer helma that initiated events resulting in death) Last Due to (druss a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the and be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a, Was an 24b. Were autopsy findings available has prior to completion of cause of death? performed? Yes 2 X No After this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မှ 1 ★ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending s after death. 1 Yes 2 No Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title 2

DHMH 17 Rev 7/2009

nas

State Registrar 12500

How brook Road cumberland MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VAN CHEEMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Month 325 Rosie /Medical Davis January 7,2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2027 Colebrooke Drive Hills Temple Hi Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Days Hours Months Yrs Director 579-46-3877 Aug. 19, 1937 VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; It is involved. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 ☐ No MD PG Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2027 Colebrooke Drive 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Program Analyst</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Leroy Richardson Dorothy Pryor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3079 Brinkley Temple Hills 20b. Place of Disposition (Name of cemetery, crematory or other place) Road #102 Md. 20748 Geri Davis/daughter 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 1/30/10 Landover Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death mediate Cause (Final **Physician** ArTeriosci disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical the. attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 📈 o 1 □Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred 1+1Natural 5 Pending nours after death, neral Director: Af illed in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300/

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04:28A M 26,2010 <u>Evelyn Helen DeMarco</u> January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F 88 **Director** 09/19/1921 Massachusetts 021-18-8580 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 1X Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20850 15308 Diamond Cove Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify. \$ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George County 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Board of Education School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Flynn Robinson William Foster Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0878 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is n
any injury or other trau 14606 Keeneland Circle, Gaithersburg, MD <u>Gay DeMarco</u> Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/28/10 Smithsburg, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Jefferson Chapel Funeral Home Beliet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate interval Between shock, or heart failure. List only one cause on each fine. Immediate Cause (Final Days **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 sl autopsy performe 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day, Year) Injury 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

Steven Dolinsky

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

911

Russell

D 20148

Ave. Gaithersburg, MD

January 26,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 9, 2010 Lena Mae Dorsey January 11:15 am^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11045 Harry Riggin Road Princess Anne Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 578-03-5382 82 02-17-1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2 No MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11045 Harry Riggin Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Switchboard Operator 12 Holly Center none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Jenkins Daisey P. Dryden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Pinchak/daughter 30266 Jumiper Lane, Princess Anne, MD 21853 ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Beechwood Cemetery 01/12/2010 Princess Anne, Maryland 4 Donation 5 Dother (Specify) 24. Sonature of Funeral Service 22. Name and Address of Facility Hinman Funeral Home £1 M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. I mediate Cause (Final sease or condition resulting in death) MCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) art I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medic at Examiner must be notified at

filed within 72 hours after death v Hygiene.. ither than "natural", or Items 23a

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other trainmant.

Baltimore, Maryland 21215-0036

Examine burial-tran and physician Physician/Medical the as attending p been signed by the should be detached by Completed certificate has director, page 2 Be မ After this Certification: To the Hospital or Attending within 24 hours after death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

9∐Unknown
ns contributing to death but not resulting in the underlying cause given in f

examiner?	/
27. Manner of Death	
1 Natural	5 Pending

2 Accident

3 ☐ Suicide

29a. Certifier

28a. Date of Injury (Month, Day Year) 28b. Time of investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)	2 Medical Examiner:	O ar
29b. Signature and	title of certifier	

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print 30. Name and address of pe 5

State Registrar

Medical

31. Date filed (Month, Day, 32. Registrar's Signature

		,	For State Registrar		State of M	Maryland /		artment of H		nd Mer		ene g. No. 20	10	02612
			Decedent's Name (First, N	iddle, Last)							Date of Death		Vear	3. Time of Death
	Physici		Donna Anita	a DeI	Launey					-	Month	20 20	Year	1100 PM
-	/Medic Examin		4a. Facility Name (If not instit	ution, give :	street and number	er)		4b. City, Town, or	Location of			4c. County		
			301 West Ma:	n Str	ceet				rpsburg				shing	
	Funeral		5. Social Security Number	6. Sex	7 M 2 X F	Age (In yrs. last b	• ,	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year)	Cour	
	Director		215-36-6071		1 M 201 F	70	Yrs.			De	c.17,1	939	Mary	vland
	and w		Usual Residence of Deceden 10a. State 10b. Co.			10c. City, To	wn or Lo	cation					1	0d. Inside City Limits
	the Marylan 28a-f show notified at	ō		7 10 2			Ch	a san abusaa						1 X Yes 2 □ No
	the 128a-	rect	Maryland 10e. Street and Number	Vashir	igton		SHE	arpsburg 10f. Zip Code			10	g. Citizen of W	/hat Cour	itry?
	with ya	ā	301 West Ma	n Str	coet				21782	2			USA	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show droit Exactivet must be rodified at	Funeral Director	11. Marital Status		12. Was Decede	nt Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba			Yes or No-			an Indian,
w	ir iter		1 ☐ Never Married 2 ☐	Married	Armed Force	s? X No				, Puerto Rica	an, etc.)		k, White,	etc.
21215-0036	ral", o	ğ	₩Widowed 4 Divo	ced	If Yes, Give Year or Date			1∐Yes 2∏XNo	Specify:			Specify	Wh	nite
5-0	72 hc	Completed	15. Dece (Specify only h	dent's Edu	cation e co <i>mpleted)</i>	16	(Give	dent's Usual Occupa kind of work done d	lurina most	of working	1	6b. Kind of Bu	siness/Ind	dustry
21	ithin ne.	d d	Elementary/Secondary (0-	<u> </u>	College (1-4d	or 5+)	life.	DO NOT use retired,)			m	m:	G-1
	filed within Hygiene. wther than "		12 17. Father's Name (First, Mid	dla Loat)				Secreta		r's Name (F.		Retail Maiden Surnam		e Sales
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, if a Marical Examine to must be notified at	Be										nia E		lberger
Ž	should be f and Mental s marked o umatic eve	ပ	Harry Gleni 19a. Informant's Name/Rela	n Rohi		10	ah Mailir	ng Address (Street a						
Ma	d 2 sl th an 17 Is i		Sue Ann DeLa			I								
	ges 1 and 2 nt of Health it frem 27 is or other tra		20a. Method of Disposition	mey -	- Step L	20b. Place	of Dispo	sition (Name of matory or other place	ar Dr.	Date	2	Oc. Location -	City or To	own, State
ō	Pages nent of nnt: If its ury or o		1 ☐ Burial 2 XCremat		Removal from Sta			matory or other place g Cremato:		an 22	2010	mithsh	ura.N	Maryland
Baltimore,			4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Ser		ee)	DIIII CI IS		sborre Are				AIII CIIDD	arg/i	aryrana
Ba	permit. Departr Importa any Inju			16	Sh			25 S. Con				lliams	port	MD 21795
			23a. Part 1. Enter the diseas	e, or compl	ications that caus	sed the death. D	o not en	er the mode of dyin	g, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between
	Physician		shock, or heart failure. Immediate Cause (Final	List only or	ie cause on eaci	/		/						Onset and Death
	/Medical		disease or condition resulting in death)		Due to (or	as a consequenc	e of):	Canco						1111111111
-	Examiner	_	Constant list on diving		2									
	P .±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (or	as a consequenc	e of):							
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		o									
30,	cate be executed physician and the burial-transit	Ê	resulting in death) case		Due to (or	as a consequenc	e or):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical			d									
9 x	ding se as	/Me	IF FEMALE:	2	3c If yes outcome	me of pregnancy						and Day	te of deliv	OT!
Вох	leath certifica attending ph for use as th	ian	23b. Was decedent pregnan in the past 12 months?	· '	1 Live birt	th 2 Fetal dea		☐ Ectopic pregnancy ☐ Other (specify)	У				nth	Day Year
O.	the de	Physician/Med	1 □ Yes 2 ☑ No 9 □ Unknown		9 Unknow		. 5						_	
٦.	N requires that the description is been signed by the should be detached		Part II. Other significant co	ditions co	ntributing to deat	h but not resulting	j in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use cont	ribute to t	he cause of death?
ds	uires n sigr ld be	d by									1 ☑ Ye	s 2 No	3□ Pro	bably 4 ☐ Unknown
OS	w red s been shou	Completed									24a. Was ar	24b. 1	Were auto	opsy findings available ompletion of cause of
Re	he law e has ige 2 s	E G									autops: perforn	ned?	death?	
[a	ifficat		25. Was case referred to me	dical				-	26 Place	of Death ((1 ☐ Yes 2 Check only one		1 ☐ Yes	2 LI No
Š	/sicial	Be	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 □ Inn	atient 2 ER/	Outnatie	nt 3 DOA Othe	or.			nce 6 Oth	er (Speci	fv)
of	a Physer this eral of	H.	27. Manner of Death		28a. Date of	Injury 28t	D. Time o					w injury occurr	,,,	-57
ion	ath. T: Afte	ațio	1 ☑ Natural 5 ☐ Pe 2 ☐ Accident in	nding restigation	(Month,	Day, Year)	Injury		(? Yes 2∐N	No				
Division of Vital Records,	or Attending Physician: ufter death. Director: After this certifica in by the funeral director, p.	ific		uld not be termined	28e. Place of	Injury - At home, , etc. (Specify)	farm, st	reet, factory, office		28f	Location (St.	reet and Numb	er or Rur	al Route Number,
Ö	tal or rs afte al Dir	Certification: To	7 E Trominado			, 0.10. (0,),								
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		(Check only 2 Med		ner: On the bas	is of examination		th occurred at the tire						
	the I	Medical	one) 29b. Signature and title of ce	rtifier	and manner	r stated.		29c. License	e number		2	9d. Date signe	d (Month.	Dav. Year)
	6 ≥ 6 8		29b. Signature and the or ce	1	an.	1. 1	100		1166	1		1/	21/	15
•			30. Name and address of pe	reon who	ampleted cause	of death /Itom 22:	a) (Turns		. 100	/			(-
. 4	1-6		Michael J.					Medical_	Campu	ıs Ra	. Наое	rstown	МП	21742
	Sta	ite	31. Date filed (Month, Day,	(ear)	32. Re	fistrar's Signature		incurcar	Jampu	.b Mu	, mage	will	,	
	Regist		MAL	227	010	Service A		and .						
					-	3	PHON							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Mental Hygiene Per me, 200,02/18/2010dnb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN. **Physician** James Lee Dolby, Sr. 2010 5:42 AM $2\bar{1}$ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Denton Caroline Home for Hospice Caroline 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1 ★M 2 ☐ F 91 Maryland Director 220-03-6693 Feb. 28, 1918 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantiner must be notified at 10a, State 10c. City, Town or Location Preston Caroline 1 ☐ Yes 2 X No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21655 United States 4890 Bethlehem Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto & Tractor Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Cannon John Dolby မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4890 Bethlehem Rd., Preston, MD 21655 Health a Ruth Newnam/Daughter other permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Preston, Maryland Junior Order Cemetery 01/25/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) nonc 1 Cass /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) CATION APPROVED BY MEDICAL EXAMINER or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician Box 68760 Physician/Medical CERTIF the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for i Month Day Year in the past 12 months? 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 1 □Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1**X** Yes 2 → 10 Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To heral Director; After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of . Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funeral L Hospital 29a, Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal completely (Check only one) ind manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) effrey MD 5 n wood en ton

DHMH 17 Rev 1/2001

State

Registrar

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			For State	State of M	aryland		artment of H		nd Mental H	ygiene			
			Registrar 1. Decedent's Name (First, Middle, Last)			Ue:	lilicate of L	Jeani	2. Date of D	Reg. No.	2010	122	Dodth
Phys	siciar	n							Month	Day	Year	5. 200	M
and the same of th	edica		John Gustav DeHahn 4a. Facility Name (If not institution, give stre	at and number	1		4b. City, Town, or	Location of I	Janua		, 2010 County of Death	5:30	р ""
Exa	mine	r	Genesis Eldercare	et and number,	/		LaP1at		Death		Charles	L	
Funo	rol		5. Social Security Number 6. Sex	7. A	ge (In yrs. k	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth	9. Birth	place (State o	or Foreign
Fune Direct					88	Yrs.	Months Days	Hours	Min. Sept.	$\stackrel{\text{Day, Year)}}{1}$	921Sout	ntry) n Dakot	a
TO			Usual Residence of Decedent				l						
rylan	1	_	10a. State 10b. County		1	, Town or Lo						10d. Inside Ci	
e Ma		2	Maryland Charles		1:	ndian	-,					1 XYes	2 NO
計 9 gr 計	1	Ulrector	10e. Street and Number				10f. Zip Code			"	zen of What Cou	intry?	
ath w		<u>a</u>	2 Cypress Place					0640		L ,	.S.A.		
er de		Funeral	11. Wantai Otatus	Was Decedent Armed Forces	?	3. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origii n, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	lo-	 Race - Amer Black, White, 		
36 's aft		by L	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1X Yes 2 ☐ If Yes, Give Year or Dates:	100		1⊡Yes 2X∑No	Specify:			Specify: Wh:	ite	
-00 hour		ed l	15. Decedent's Educati		150		dent's Usual Occupa	ation		16b. Kir	nd of Business/li	ndustry	
15 in 72 in "in in the		bec	(Specify only highest grade co	ompleted)	F.)	(Give	kind of work done of DO NOT use retired	lurina most o	of working				
212 I with giene r tha		Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Navy	Diver In	struc	tor	U.S	. Govern	nment	
Ind 21215-0036 be filed within 72 hours after death with the Maryland Ital Hygiene. "natural", or items 23a or 28a-f show event, the filed of Examiner must be notified a		ne C	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Middl	e, Maiden	Surname)		
rlar Jid be Jents Aents rrked		0	Jake DeHahn					Th	ressa Scl	nultz			
ary shot and N		- 1	19a. Informant's Name/Relationship (Type.	Print)		19b. Maili	ng Address (Street a	and Number	or Rural Route Num	ber, City o	r Town, State, Z	ip Code)	
and 2 and 2 and 2 in 27 in		- 3	Frances E. DeHahn	Wife					ndian Head	·			
es 1 of He of He if iten			20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Rem	aval from State	20b. Pl	lace of Dispo emetery, crei	sition (Name of matory or other place	Januar	ry 26, 201	1 0 ^{20c. Lo}	cation - City or T	own, State	
Pag Pag ment ant: I	5	ĺ	4 □ Donation 5 □ Other (Specify)	iovai iioiii State		yland	Veterans	Cemet	ery	Ch	eltenhar	n, Mary	·land
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any initivy or other traumatic event. It is Medical Example must be retitled.	ouce		21. Signature of Funeral Service Licensee	1	M00668	8 4	2.Name and Addres Filliams F 270 Hawth	s of Facility 'unera lorne]	1 Home, P Rd., India	.A. an He	ad, Md.	20640	
			23a. Part 1. Enter the disease, or complicate shock, or hear failure. List only one of	tions that cause	d the death							Approximat	ween
Physicia	an		Immediate Cause (Final disease or condition	1-5	DIRA	+T101	V PNE	muse	FLA			Onset and I	Death
/Medic	_		resulting in death)	Due to (or as	s a consequ	uence of):	. +	7 0 70	_			7.00	11.0
Examin	er		Commentation to the state of th	PU	LM	INA	ey ta	12010	E			MONT	45
D .=		ie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	uence of):	6	15 F/6	165				
ecute and trans		Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	HL.	ZHP.	IME	TC W	JF10	777		- 1	4023	
8760, cate be exphysician at the burial-	i i		resulting in death) cast	Due to (or as	s a consequ	ience of):							
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	7	dicai	d										
Box 68 leath certific attending p	/8.8	Pnysician/Me	IF FEMALE:	. If yes, outcome	e of pregna	ncv	-				201 0 1 1 1 1		
Box leath cert attendin for use		ian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3	☐ Ectopic pregnancy ☐ Other (specify)	1		2	23d. Date of deli Month	,	Year
P.O. nat the de		Sic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	at time of di	eau 3L							
ds, P.O. I uires that the de signed by the ad be detached for	Ċ		Part II. Other significant conditions contrib	outing to death I	but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Dio	l tobacco u	ise contribute to	the cause of c	death?
rds puires n sign ld be	1	d b							1	Yes 2[□ No 3 □ Pro	obably 4 🗆	Unknown
Cord w requir s been s should		Completed							24a. Wa	s an	24b. Were aut	opsy findings	available
Ref he lav e has	,	E C							aut per	opsy formed?	prior to c death?	ompletion of c	ause of
Vital F Vital F sloian: The certificate ector, pag			25. Was case referred to medical			<u>.</u>		26 Place a	1 ☐ Yes of Death (Check only	2 No	1 ∐Yes	2 🗆 No	
f Vital Raysician: The lis certificate hidirector, page	1	n ne	examiner?	pital:	ient 2 🗆 I	FB/Outnatie	nt 3 DOA Othe	IF!	sing Home 5 Re		6 □Other /Spec	rific)	
g Physer this eral dii			27. Manner of Death	28a. Date of Inj	iury	28b. Time o			28d. Describe				
Sion of ttending Phy death. tor: After thi the funeral of		919	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, D	ay, rear)	Injury		.r Yes 2∐No	0				
Division of Vital Records, I or Attending Physlcian: The law requires th after death. Director: After this certificate has been signe of in by the funeral director, page 2 should be d			3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	jury - At ho	me, farm, str	eet, factory, office			(Street an	d Number or Ru	ral Route Nun	nber,
Div tal or A rs after al Direct		Certification: 10	,	Danieling, o	io. (opeon)				Only of 7	om, olate,	/		
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director;		edicai	29a. Certifier (Check only one) 1		of examinat								3)
To the within 2 To the comple	- 2	Med	29b. Signature and title of certifier	2.14 HIGHIO			29c. License	e number		29d. Dat	te signed (Month	, Day, Year)	
⊢ s F ŏ			Rushem 1 VO	l- ma			DOM	060	18	1-	-19-2	010	
60		1	30. Name and address of person who comp	oleted cause of	death (Item	23a) (Type.	Print)				110	ν	
(BS)10t	1		RICHARD KEIN M-S	17069	1 FER		ICPB, KIM	19 GE	18 ungre, VA	22	1485		
	State	e	31. Date filed (Month) Par Y21 201	32. Fegist	trar's Signat	ture	market.						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Amended #10e perFH FCHD, KS 1/15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 Day 14 **Physician** 2010 10:45 A M Flossie Elizabeth Dixon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Braddock Heights Vindobona Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 🗙 F Month, Day, Year) 10/28/1918 Director <u>578–18–2183</u> 91 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be multified at Director M Yes 2 No Frederick Braddock Heights MD 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? 5819 Jefferson Blvd 21703 USA Funeral son Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 14 Race - American Indian. 11 Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: 2 Specify: White 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov. General Ser. Admin 11 h and Mental Hygie is marked other th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lightly or other traumatic event any light. 17. Father's Name (First, Middle, Last) Be Sarah Frances McPherson George J Ridgeway ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5819 Jefferson Blvd, Braddock Heights MD 21703 J. Edward Riggan, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lovettsville VA Union Cemetery 1/18/2010 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. John T Williams Funeral Home, Brunswick MD 21716 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dios tolic consestue months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner per trophuc 10ars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown In su Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D32073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 North ave, Brumswick HD Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Irene C. Dickerson 2010 6:45p January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Catonsville</u> Baltimore Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 🖸 F March 19,1924 Director 85 Maryland 579-26-3427 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examin or must be rectified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Directo Maryland Prince Georges Greenbelt 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 United States Funeral 22 Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No \$ Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Aldridge Estella Mae Brashears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21043 3032 Oak Green Circle Unit A Ellicott City, Maryland <u>Dayna Betz / Granddaughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Hill Cemetery1/18/2010 Monrovia, Maryland 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NTRAVENTRICULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ CARDIOVAS CULLAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed? Ves 2.200 1 ☐Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural
2 ☐ Accident death. 1 ☐ Yes 2 ☐ No spital or Attendi lours after death. neral Director: A rilled in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-13-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 210 BUSINESS UMA DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Libratus. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ 11:45рм Dorothy A. Eppler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Arden Court -Kensington Kensington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛭 F April 03. Months Days Hours Min. Country) Nebraska 95 Director 496-01-3602 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1
✓ Yes 2

No Maryland Montgomery Kensington 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 4301 Knowles Avenue 20895 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural", 3 X Widowed 4 Divorced Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Flementary/Seconday (0-12) Loan Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even once. 27 is marked o traumatic eve Mental ည Caloma Alice Brinegar France Oscar Arnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18852 Vista Drive. Buena Vista. Colorado 8<u>1211</u> Phullis Ruth Johnson - Daughter 20b. Place of Disposition (Name of Date June 1997)

Johnson County Mem. 01/15/2010 Overland Park, Kansas

Gran O1/15/2010 Overland Funeral Home, Inc. 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service / ce 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Seizure Disorder Medical Due to (or as a consequence of) Examiner End Stage Dementia Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examiner District as a consequence of use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be execu Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Į. Month Day Year 5 Other (specify) Pregnant at time of death ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by be det þ Records, The law requires 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital | director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 K Nursing Home 5 - Residence 6 - Other (Specify 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2

State Registrar

10

person who completed cause of death (Item 23a) (Type, Print)

M.D.

Alpana Goswami.

31. Date filed (Month, Day, Year)

D27660

11125 Rockville Pike, Suite 110, Rockville, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ever 900 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegan umbedand Maryland Health If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) MD 1 🗆 M 2 🔾 F Months Days Jun 25 Director 219-03-9314 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 219 Race Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natures" any injury or other transmissions. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Specify: white Completed 3 XWidowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Myrtle Agnes (Norris) Logue Theodore Logue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
219 Race Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Leo Everly Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/18/2010 Cumberland MD 4 Donation 5 Other (Specify) 21. Signal re of uneral Se 22. Name and Address of Eacility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or a la Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to to the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths?
1 ☐ Yes 2 XNo Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should within 24 hours after death.

To the Funeral Director, After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 🗹 No Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ウト Dodg HEUN MAN 19 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Luise Anna Katharina Engelhardt 01 2010 8:40 P. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 236 BRADDOCK ROAD FROSTBURG ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Min. 1 □ M 2 🖫 F Months Hours 09/13/1940 550-53-1363 Yrs 69 GERMANY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits ALLEGANY FROSTBURG 1 🗆 Yes 2 🔀 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 236 BRADDOCK ROAD 21532 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force: Black, White, etc. 1 Never Married 2 XMarried 1 Yes 2 2 X No 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1) EDUCATION College (1-4 or 5+) Elementary/Seconday (0-12) 2) CHURCH 5+ TEACHER 2) ORGANIST & CHOIR DIR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname GEORG KOEHLER KATHARINA SCHWAB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HERMANN ENGELHARDT / HUSBAND 236 BRADDOCK ROAD, FROSTBURG, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) MICHAEL CEMETERY 01/19/2010 FROSTBURG, MD 21. Signature 22. Name and Address of Facility UPCHURCH FUNERAL 202 GREENE STREE of Funeral Sei 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) vancrea Due to (or as a one quince of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

Other:

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2031551

HWM

28c. Injury at work?

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify,

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician. Medical Examiner Examir and

Physician/

Medical

10a. State

Examiner

Funeral

Director

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Examiner must be notified

Director

Funeral

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Completed

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Medical

Department of Health and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, the Me once.

72 hours after

filed

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. use as the burial-transit Medical F physician signed by has certificate this after death completed filled in by 24 hours

Division of Vital Records, P.O. Box 68760

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Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

2 No

5 Pending

Munie

Day, Year)

JAN 19

Investigation

determined

ann

6 Could not be

1 Tes

27. Manner of Death

1 Natural

Accident

Suicide

4 Homicide

(Check

only one)

orrine

31. Date filed (Month,

29b. Signature and title of certifier

8 State

within 2

National

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

920

32. Registrar's Signature

28b. Time of

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Nam	e (First, Middle	e, Last)		Cel	lincat	e OI L	Jean		2. Date of D	Reg. No eath	- 21		3. Time o	f Death
Physicia: Medic		John		V.		Espos	sito				Month	Da	y Y	ear	1	15YC
Examin		4a. Facility Name (if	not institution	, give street and r	number)		4b. City,	1	Location	1	1	4c	. County of		,	
, E		(Destern 5. Social Security N	mal	Kegional	7. Age (In yrs.	(Cente	If Under		ber If Under		8. Date of Bi	rth 7		gay	lace (State of	or Foreign
Funeral Director		220-16 Usual Residence of	-6823	1 LM 2 L	F 82		Months	Days	Hours	Min.	Dec	9, 19	927	Count	MD	or i dreigh
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ctor	10a. State	10b. County	llegany	10c. C	ity, Town or Lo	cation Imber	land						1	0d. Inside C	City Limits
or 28a	Director	10e. Street and Nur					10f. Zip					10a Cit	at Coun		3 2 LI NO	
with t	Funeral	608 W	/ellingte	on Lane					21	502		g		JSA		
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To the Hospital or Attanding Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 2 should be detached for use as the burian to the completed filled in by the funeral director, page 3 should be detached for use as the burian to the completed filled in the completed filled in the complete filled in the completed filled in t	Certificate:	3 Suicide 4 Homicide	6 ∐ Could determ	inod 28e. Pla	ace of Injury - At h ilding, etc. <i>(Speci</i>	nome, farm, str fy)	eet, factory	, office			28f. Location City or To			or Rural	Route Numi	ber,
Hospita 24 hours Funeral ted fille	Medical	(Check 2	Medical I	Physician: To the Examiner: On the	basis of examination	on and/or inves	tigation, in	my opinio	n, death o	occurred a	t the time, date	and place	, and due to	the cau	se(s) and ma	anner stated.
o the	M	only one) 3 29b. Signature and	Certifying	Nurse Praction	er: To the best of n	ny knowledge,	death occu	red at the	e time, dat	e and plac	ce, and due to t	he cause(s	s) and mann te signed (A	er as sta	ted.	
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7		30. Name and addr			ause of death (Ite	m 23a) (Type, I	Print)	0111		,	20	0.10		+		6 D
The Stat	e	31. Date filed (Mont	h. Day, Year)	K,MD	Registrar's Sign	Sture /	VD	KIV	= (un	BERL	HUI	0, M	10	215	04
Registra		JA	N 13	2010 E	que so	Ture foar	-									

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

3305 N. Leisure World Blvd., Silver Spring, MD 20906

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

James A. Rossi, MD

JAN 19

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00p M John Carter Finley January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Arcola Nursing Home Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 8. Date of Birth (Month, Day, Year)
June 03, 1 Funeral 7. Age (In yrs. last birthday, Days Hours 1 X M 2 T F Director 228-38-3628 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Exercises must be notified an once. 1 ☐ Yes 2 X No Directo Maryland Montaomeru Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8601 Bradford Road 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 NoKohean If Yes, Give Year or Dates: (Jan 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 🛣 No Specify: African-American 3 Nidowed 4 Divorced War 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Administration Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd Raymond Finley Sadie Carter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Finley - Daughter 8601 Bradford Road, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 01/19/2010 Brentwood, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prevnonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) P.O. 1 signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Wo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manne Death 28b. Time of 28a. Date of Injury (Month, Day, Year) After 5 Pending investigation spital or Attendir nours after death. neral Director: Af y filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064624

Registrar
DHMH 17 Rev 1/2001

State

Sunner

Gaithersborg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDEES SHARMA
31. Date filed (Month, Day, Year)

19

743

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:30FM Month Henour **Physician** alter 2010 lanuar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) **Funeral** 1 M 2 F Days 223 48 7080 Director Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show be notified at 10a. State 10c. City, Town or Location 1 Yes 2 No Director Alexandria 10g. Citizen of What Country? 10e. Street and Number USA 23a ural", or items 23a I Examiner must b 3701 Rolling HILLS Funeral death Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eliza Blanks ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Macon Dr. Alexandria, 6923 Kandolph 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 1-23-2010 Alexandria, VA 4 Donation 5 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Itome 6 814 Franklin Street, Alexandria, VA 22314 23a. Part 1. Enter the disease, or compressions that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final aortic aneurysm **Physician** I horacic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hyperteusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to to as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) g physician a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year for d by the at detached f 1 Yes 2 9 Unknown 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe med? 2**X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 🗆 Nursing Home 2 No 1 Inpatient 3 DOA 5 Residence 6 Other (Specify) 2 ER/Outpatient ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: 1 Natural
2 Accident Injury Pending investigation s after death. 1 TYes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) ò determined 4 Homicide filled in I 24 hours a Hospital 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES - 000 15,2010 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEI 600 North Wolfe St, Baltimore, MD, 21287 71NG (Month, Day, Year State JAN 2 0 2010 Registrar

		State of Maryl				Mental Hy	giene				
		State Registrar	Ce	ertificate of L	Death		Reg. No. 2	ПÛ	02621		
Physician		Decedent's Name (First, Middle, Last)		2. 11		2. Date of De Month	Day	Year	3. Time of Death 6:11p M		
/Medica	1		ouise G	Grubb	Location of Death	Januari	4c. County		0.11b w		
Examine	r	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			ver Spri				gomery		
Funerai			yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birtho	place (State or Foreign		
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pu >		Usual Residence of Decedent	. City, Town or L	costice				T ₁	0d. Inside City Limits		
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with with		13112 Broadmore Road			20904			u.s			
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or ite		1 Never Married 2 Married		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	o Rican, etc.)		ck, White,			
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should and Mer s marke umatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	iling Address (Street	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zij	Code)		
s 1 and 2 should be filed within 72 hour f Health and Mental Hygiene. Item 27 is marked other than "natural other traumatic event, IIs Modical E.		Carole V. DaCosta - Daughter	13112	2 Broadmor	e Road,	Silver :	Spring,	Mary.	land 20904		
of He of He of Titlen		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Disp cemetery, cr	position (Name of ematory or other plac	e)	Date	20c. Location -	City or To	wn, State		
Pages ment of tant: If it jury or o		4 □ Donation 5 □ Other (Specify) G	ate of t	Heaven Cem	. 101/2	5/2010	Silver	Spri	ng, MD		
permit. Pages 1 and 2 D partment of Health s Important; If item 27 is any injury or other tra		21. Signature of Eureral Service Licensee MO0707							Home, Inc.		
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ting F	0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Yea	28b. Time Injury	/ Worl	yat ⟨? Yes 2 ∐No	28d. Describe	how injury occur	red			
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To the company	È	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,									
3		• (/)/	N		2503		Januar	y 13	, 2010		
		30. Name and address of person who completed cause of death			Cillian	Cotica	Marin	.d 00	010		
State		Shailesh Sheth, M.D., 1500 31. Date filed (Month, Day, Year) 32 Registrar's S	Signature	bren Koad,	suver	spring,	marykar	ıa 20	710		
Registra		31. Date filed (Month, Day, Year) 32 Registrar's S	1. 4	arked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2035 **Physician** Invice 2010 Sylvester M. Garris, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince 2 2 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Min Days Hours 1 M 2 □ F 10-2-1956 53 Newport News, VA Director 227-82-1040 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20032 United States 4660 Martin Luther King Avenue, SW Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 K No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gasoline Co. Jiffy Lube, Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Watson Louis Garris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4660 Martin Luther King Ave, SW Washington, DC 20032 Vaneta Garris - Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 1-21-2010 Riverdale, Maryland 22. Name and Address of Facility John T. Rhines Funeral Home, LLC gnature o Funeral Service Licens, e 3005 12th St. NE, Washington, DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause (Final season or condition Theros der oTic **Physiclan** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duit to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760, physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) o ed by the a 9 Unknown ٦. s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊟Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending e Funeral Director; Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

State Registrar 31. Date filed (Month, Day,

JAN 2 0 2010

Year)

32. Registrar's Stg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registral Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Harold Reginald Greene 3:50 A 13 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 5703 Ottawa St. Oxon Hill P.G. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours 1**⊋**M 2□ F Months Days 79 579-36-8648 Wash, D.C. 8-5-1930 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Oxon Hill P.G. 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20745 U.S.a. 830 Neptune Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2□NoFeb53 IYes, Give Year or Dates: Oct53 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ▼ No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government College (1-4or 5+) Elementary/Secondary (0-12) Clerk 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jeanette Johnson George Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 830 Neptune Ave. Oxon Hill MD. 20745 Phyllis Greene (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. 1-20-2010 Brentwood MD. 22. Name and Address of Facility Hunt Funeral 908 Kennedy St. N.W. Wash, 21. Signature of Funeral Service Ligensee 20011 Franco Approximate Interval Belween Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. delivery

6 Other (Specify) Son Lome

26. Place of Death (Check only one)

5 Residence

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Other: 4 Nursing Home

1 Tes 2 No

Physician /Medical Examiner

burial-transit

physician the for use as

the detached

certificate has

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After

Physician

/Medical

Examiner

10a. State

MD.

Funeral

Director

28a-f show

Director

Funeral

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Completed

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traumatic event, the Medical Examinar must be notified at

naturel

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, It a Media 2008.

the Maryland

death with or Items 23a or

filed within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examiner ate has been signed page 2 should be del Be Completed by director, ٩ Certification: the near-thin 24 hours after death. to the Funeral Director: Af

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

Tr Thur

31. Date filed (Month, Day, Year)

JAN 1 9 2010

29b. Signature ary

Hospital:

5 Pending investigation

6 ☐ Could not be

determined.

1 Inpatient

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

Hospital or Attending Physician: The law requires that the death certificate be executed

To the within 2

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	Due to (or as a consequence of):	gcer
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	
that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
	ons contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 12Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3 DOA

28c. Injury al Work?

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

License numbe

State Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 01-10-2010 6:50 JAMES D. GRIGSBY Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 √2 M 2 □ F 08-08-1922 87 Director 579-36-7327 Usual Residence of Decedent or 28a-f shov 10h. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 1X□ Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20020 USA 3144 Westover Drive, 12. Was Decedent Ever in U.S.
Armed Forces?
1 M Yes 2 □ No
If Yes, Give 1939–1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced "natural" Completed and Mental Hygiene.
is marked other than "natur-15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Dispatcher other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Lucille Hines James Thomas Grigsby Department of Heath and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 Southwest Hooker, Portland, OR 97201 Robert Sullivan/cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Hill Cemetery 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01-15-2010 Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MO Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, Examine if any leading to immedia cause. Enter Underlying Due to or as a considuence of burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown P.O. 1 ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 A No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this eted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work's Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only or Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

32. Registar's Signature

7701 Carroll Avenue, Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasreen Kango, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Emily Frances 5327 P.M 12 , 2010 January /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Examiner McCready 5. Social Security Number Crisfield Somerset Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F Months Days Hours 68 215-38-0955 Director July 19, 1941 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Crisfield 1**⊈**Yes 2 □ No Somerset Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.

Important: If them 27 Is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examples or 2. Cove Somers 21817 U.S. A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Crisfield Assistant 12+4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fosque Renzie Dennis Mary ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fosque Teresa - Daughter 5825 Strathmore Manor Circle Lithonia 6A 30058 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crisfield, med. Hopewell 1/18/10 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name and Address of Facility 21. Signatur@of Funeral Service Licensee Anthony E. Ward F.H. E. Ward Crisfield 314 Cove 5+ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ronsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ T 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) A8098

State Registrar

DHMH 17 Rev 1/2001

201, HALL HIGHWAY,

CRISEIELD, MD 21817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· YITAY

31. Date filed (Month, Day, Year)

KARUMBUNATHAN

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ YARUMAT 3.30 2010 Ronald Edward Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OF BALTIMORE BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 8 1940 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday, **Funeral** 1 ☑ M 2 🗆 F Hours Director 213-40-0853 69 Usual Residence of Decedent Show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sh notified a 1 Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral 21157 USA 306 Wayne Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, 2 No 1959 Armed Forces? Black, White, etc. REEN, RONALD þ 1 Never Married 2 Married 1 Yes : 1 ☐ Yes 2 🔀 No Specify: 1962 Specify: Completed 3 Divorced 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) Car Salesman Heritage Auto item 27 is marked other Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ٩ Hilda Taylor Stuart F. Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health Westminster, MD 21157 wife 306 Wayne Ave. Patricia Green 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evergreen Mem. Park 1/14/10 Finksburg, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lic 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Priysician/ ARDIOUENIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NON ISCHEMIC CARDIOMYOPATHY Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of and Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day 4 Pregnant 9 Unknown Month Year Pregnant at time of death 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ISCHEMIC BOWEL Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed s been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed' 1 Ves 2 No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours a 'er death'

To the Funeral Director: After to completed filled in by the tunera or Attending 1 Natural 5 Pending work 1 🗌 Yes 2 🗐 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES OOD MB BS JANUARY, 10, 2010 WISL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJEEV GUPTA, SIMM HOSPITAL OF BALTIMORE, 2401 W. BELVEDERE AVE; BALTIMORE, MD 21215 31. Date filed (Month, Day, Year) State Registrar IAN 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02630 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death 050 M Physician/ TRICIA OAGE Month 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospice of the Chesapeake Anne Arundel Linthicum Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🗷 F Hours Sept. 29, Year) Pennsylvania 214-42-4739 65 Director Usual Residence of Decedent or 28a-f show notified at show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2X☐ No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be Funeral 7618 Beach Drive 21122 USA 23a items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 🖪 No Black, White, etc. 1 Never Married 2 Married ō ģ Baltimore, Maryland 21215-0036 White 1 🗌 Yes 2 🏋 No Specify: If Yes, Give Specify: "natural", 3 - Widowed 4 - Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public Health Advisor Federal Government permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, <u>u</u>t Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Evelyn M. Doyle James F. Pendergast 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7618 Beach Drive, Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Robert J. Hoage/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Jan Date 2010 18, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 St Other (Specify) entombrant Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between PERLIVASCULAR Immediate Cause (Final EPITHEUDIO CELL TUMOR Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). o the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

o the Funeral Director: After this certificate has been signed by the attending physician and empleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy KNOWN EMBULI performed? 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 No DICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) HOUSE 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certif 3,2010

State Registrar 31. Date filed (Month, Day, Year)
JAN 14

DEFENSE

MAHWAY

who completed cause of death (Item 23a) (Type, Print

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Month JAN Physician/ 12:30 AM WILBUR, HOYMAN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Hours Min. Month, Pay, Yea 219-46-0340 **Director** 6 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: I frem 27 is marked other than "naturalt", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Y Yes 2 ☐ No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 635 Henderson Avenue 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 🗌 Widowed 4 💢 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Bakery Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James William Hoyman Lucille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 i Treasa A. Hoyman / Daughter 12322 Williams Road, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Mt. Zion UMC Cem. 01/23/2010 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LRINARY INFECTION WEEK Medical Due to (or as a consequence of) **Examiner** SEPSIS WEEK Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month Year Pregnant at time of death signed by the a 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown QUADRIPLEGIA, CHRONIC KIDNEY DISEASE page 2 should 24b. Were autopsy findings available prior to completion of cause of death? SA NODE DISFUNCTION. 24a. Was an COPD certificate has autopsy performed' 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

(Check only one) 29b. Signature and title of certifier

CATHERINE SMITH

nas

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

18179

22 S. GREENE ST., BALTIMORE, MD 21201

29d. Date signed (Month, Day, Year)

2010

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	-	For State Registrar	Please			d / Depa		. Ensure A Health and M Death	Mental Hyg			02632
Physicia /Medica		1. Decedent's Name (erta		Hewit	t	2. Date of Deat Month 01/19/	h Day	Year	3. Time of Death 3:00 A.M.
Examine		4a. Facility Name (If n	not institution, giv n Livin					r Location of Death nberland		4c. Co	unty of Death All	Legany
Funeral Director		5. Social Security Nun 215–18–853	31 1	ex □M 2∏ F	7. Age <i>(In yrs.)</i> 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/23/	Year) 1921	Cou	place (State or Foreign intry) 'Yland
Maryland -f show fed at		Usual Residence of D 10a. State 1 MD	lecedent lob. County Allega	any	10c. Cit	y, Town or Lo	ocation Cumberla	nd				10d. Inside City Limits 1 □ Yes 2 □ No
th with the 23a or 28a ast be roff	ral Director	10e. Street and Numb	er Rayne Dr:	ive			10f. Zip Code	502	1	0g. Citizen	of What Cou	intry?
I's a	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2 XNo e No		Was Decedent of HI Yes, specify Cub	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		Race - Amer Black, White, ecify:	
01 01 12	Completed	(Specify Elementary/Second	5. Decedent's Ed y only highest graduary (0-12)	ducation ade completed) College (1-	4or 5+)	(Give life.	DO NOT use retire	during most of world			of Business/Ir	
e filed val Hygie I other t	Be Co	12 17. Father's Name (Fi	irst, Middle, Last,				omemaker	18. Mother's Nam	ne (First, Middle, M		Home rname)	
hould by d Ments marked matic e	ဂ္	George 19a. Informant's Nam	no/Polationship (Herbe	rt	_	iley	Mary and Number or Ru	Mati			Leydig
1 and 2 sl Health an tem 27 ls i	ł	William 2	R. Hewit			806		ive. Cum	perland.	MD		
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medianone.		1 Burial 2 4 Donation 5	Cremation 3 ☐ ☐Other (Specif	y)	state	Vet Ce	m @ Rocky 2. Name and Addre	v Gan 01	ams Fami	ly Fu	neral	one, MD Home, P.A. 21502
Physician /Medical Examiner	Examiner	23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death) Sequentially list cond if any, leading to immeduse. Enter Underly Cause (Disease or in that initiated events	failure. List only inal	a	or as a consequence of a consequence	vila uence of):	1	ng, such as cardiac	_	est,		Approximate Interval Between Onset and Death 3 clays 10 days
be icia bur	by Physician/Medical Ex	resulting in death) Last IF FEMALE: 23b. Was decedent p in the past 12 m	pregnant	d23c. If yes, out	irth 2 🗌 Feta	ancy	□ Ectopic pregnan	су		23d	I. Date of deli	very Day Year
at the dead by the a stached for	Physic	1 □Yes 2 □ I 9 □ Unknown	No	9 🗆 Unkno			Other (specify)		00 5:11			
v requires that the d been signed by the should be detached	ted by	Part II. Other signific		when the contributing to de			inderlying cause giv	ven in Part I.	1 \(\text{Ye}			the cause of death?
siclan: The law r certificate has be irector, page 2 sh	Completed									ned? No	prior to c death?	topsy findings available completion of cause of
ding Physiclan: h. After this certifici	tion: To Be	25. Was case referred examiner? 1 Yes 2 27. Manner of Death Natural 2 Accident		28a. Date (Mont	npatient 2 of Injury h, Day, Year)	ER/Outpatie 28b. Time of Injury	of 28c. Inju	ner: 4 Vursing H	th (Check only €n ome 5 ☐ Reside 28d. Describe ho	ence 6		sify)
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (Si City or Town		lumber or Ru	ral Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	(Check only 2 one)	™edical Exa	nysician: To the miner: On the ba and mann	asis of examina	wledge, dea ation and/or in	nvestigation, in my	ime, date and place opinion, death occu	irred at the time, d	ate and pla	ace, and due	to the cause(s)
on with	2	29b. Signature and tit	le of certifier	alu	NA	10	29c. Licen	4 981		faru	signed (Month	20, 20/0 Land, Vid
nas		30. Name and addres	TER F	HALA	105	100		ringto	Court	Cu	mberl	land, Kd
Stat Registra		31. Date filed (Month,	V 2 0 201	O Send	egistrar's Signa	face	fled	J				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Helen Hurlock Physician/ January 18, 2010 1:03 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2609 Dawson Avenue Montgomery Silver Spring Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2¥□ F Jan. 14, 1918 Country) Virginia 92 Director 229-01-8028 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🎦 No Maryland Montgomery Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2609 Dawson Avenue 20902 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married ģ Yes 2 No Yes, Give filed within 72 hours after 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Clerical Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Alanzo Appersan Fidella Yates Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Ray Bodmer/Friend 8904 Briandale Lane, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 9 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State cemetery, crematory or other place injury o 4 ☐ Donation 5 ☐ Other (Specify) Oak Hill Cemetery 2010 Fredericksburg, VA ²². Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd,. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one puse on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or illigary that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No that the death Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be funeral director 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Director; Af Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) Jan. 18, 2010 29c. License number MD D61083 20

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar
DHMH 17 Rev 7/2009

State

varke

address of person who completed cause of death (Item 23a) (Type Print) Thanko , MD who completed cause of death (Item 23a) (Type Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Herbert 12:45 pm Harvey January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) April 03, 1922 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Germany 1 🛛 M 2 🗆 F Days Months Hours Director 109-18-2299 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 403 Russell Avenue, #204 20877 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Benno Heppenheimer Margot Lebrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lila Harvey - Wife #204. Gaithersburg, MD 20877 403 Russell Avenue. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Spacify) Garden of Remembrance 01/15/2010 | Clarksburg. Maryland 21. Signature of Funda Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MODZOG 1800 New Hampshire Ave., Silver Spring, MD 20904 n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Memoria disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner graton Sequentially list conditions, if any Lading to it, and officences. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death Lage. Physician/Medical Examiner as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t of o ertifie 29d. Date signed (Month, Day, Year) 15+1 110061302 1/13 2010 30. Name and address/of person who completed cause of death (Item 23a) (Type, Print) Atul RoHatgi, 8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D.State 19 Registrar

100 12th Cm

Herber

Forse

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard A. Harnest 2010 Janua<u>ry</u> 18:14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 ₹ M 2 □ F Months Days Hours Mar. 6. 1948 Texas 579-64-9028 61 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Hyattsville 10a. State 10b. County 10d. Inside City Limits Directo Maryland Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10820 Pleasant Acres Drive 20783 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. ≥ 1 X Never Married 2 Married If Yes, Give Year or Dates.1968-1971 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (9-12) College (1-4 or 5+) Elevator Installer private Be 17. Father's Name *(First, Middle, Last)* Earl Miller Harnest 18. Mother's Name (First, Middle, Maiden Surname) 2 Marjorie Dayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9219 Twin Hill Lane Laurel, Maryland 20708 19a. Informant's Name/Relationship (Type, Print) Robert E. Harnest -brother 20a. Method of Disposition
1 ☐ Burial 2X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 1/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma Signature of Funeral Service Ligensee Sould 0/30 Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (of as a consequence of) Examiner MA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin physician and s the burial-trans Due to (or as a consequence of) Physician/Medical certificate be attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been signage 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2X N 2 X No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 12+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Padma Chirumamilla,

JAN 19 2010

31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

32. Registrar's Sign

M.D. WAH 7600 Carroll Avenue Takoma Park, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 02636 Rosemary R Howe State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 24, 2010 **Medical Examiner** Rosemary Reynolds Howe 2206 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 8505 Springvale Road #6 8505 Springvale Rd. Silver Spring Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 516-18-9990 Days Hours Director Country) Montana 88 Oct. 16, 1921 1 M 2 x F Yrs Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 XNo tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 這 8505 Springvale Road, #6 20910 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XX No specify: Specify: White δ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Secretary Medical 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Michael Reynolds Be Viva May Hewett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George W. Howe/Son 20 Hilltop Road, Silver Spring, MD 20910 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Ħ 1 Burial 2 Cremation 3 Removal from State Jan. 27, 2010 mportant Metropolitan Crematory 4 Donation 5 Other Specify Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Mehard L Heles MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Marchen, Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transi sician/Medical 4a, per ME 2/25 , 23a,27 **PartII** X UNPENDED AMENDED attending physician or use as the burial c901 3/19/10 TT er The law requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month 2 Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö signed by 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, P. 1 Yes 2 No 3 Probably 4 ✔ Unknown Chronic pneumonitis; Dementia Completed has been page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? certificate ✓ Yes 2 No 1 🗸 To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other: Scene this 2 No ۲ 1 V Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural death. Director: d in by the f Pending 1 Yes 2 No 2 ___ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) 4 PEND Konk O.C.M.E. January 25, 2010 30. Name and address of person who completed cause of death (Item 23a)

State

Registra

Ana Rubio MD.

31. Date filed (Month, Day, Year) 1010

record

2. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Helen Hensley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Cumberland Allegany 5. Social Security Numbe . Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 Months Davs Hours Min. Country) 041-20-7755 85 **Director** 05/23/1924 Hampshire Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 516 Louisiana Avenue 21502 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give 1 ☐ Yes 2 🔀 No Specify. Specify: Completed 3 X Widowed 4 Divorced Year or Dates White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72...th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sheldon Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 Louisiana Avenue, Cumberland, MD 21502 1 and 2 s of Health item 27 Maxine R. Thomas / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 X Burial 2 Cremation 3 Removal from State 01/12/2010 Triangle, 4 ☐ Donation 5 ☐ Other (Specify) Quantico Natl Cem. 22. Name and Address of Facility Adams Family Funeral Home, tur of Funeral Service Live Sign 21502 404 Decatur Street, Cumberland, MD 23a, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SUBARACHNOID Physician/ HEMORNHAGE HRS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RUPTURED EREB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Dav Pregnant at time of death detached the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No Yes Physician; funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? e Hospital or Attending Physic n 24 hours after death. e Funeral Director: After this ce oleted filled in by the funeral direa 2 No Other: 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed (Check within 2
To the Certifying Nurse Practioner: To the best of my knowledge, do 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) pustion Vanu

Registrar DHMH 17 Rev 7/2009

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arked

200 Glenn Street, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano J.

31. Date filed Mont

barrera, M.D.,

32. Registrar's Aignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 2010 NOVELLA HUNTER 4:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges 6803 Randolph St. Hyattsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Birthus SC 1 □ M 2 🕱 F Months Days Hours Min. (Month, Pay, Year) 926 577-48-7395 Aug. Director 83 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Hyattsville MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 USA 6803 Randolph St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 K Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Elevator Operator State Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Garner Henry Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 Randolph St. Hyattsville, Md. 20784 Joshua Hunter-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 1-15-2010 Cheltenham, Md. Signature of John and Service Licenses Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiac Arrest Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin physician and the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Cther (specify) Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag Yes 2 K No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 X Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No

Box 68760 P.O. Records, Hospital or Attending Physician; **Division of Vital**

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009

State

Medical

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32. Registra 's Sign

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2100 Penn. Ave.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

NW

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DC9603

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) January 13, 2010

City or Town, State)

Washington, DC 20037

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Susan H. Houseman, MD

2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

only one)

29b. Signature and title of certifier

JAN 2 0 2010

29a. Certifier

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificete be executed P.O. Box 68760,

Physician

/Medical

Examiner

10a State

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Funeral Director

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Examiner

attending physician and for use as the burial-tran funeral director, After within 24 hours after death.
To the Funeral Director: completely filled in by the fi

of Vital Records.

Division

death.

within 24 hours a

by Physiclan/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIT HATE DILETTA W 44T DEFENCE HIGHWAY ANAPOLIS MD 2140/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NATHANTEL HAWKINS 6:35 P M January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 817 Stag Way Ft. Washington Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 | F Apr. 27, 1926 'nС Director 83 226-38-9661 Usual Residence of Decedent ms 23a or 28a-f show must be notified at ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ft. Washington Prince Georges 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 USA 817 Stag Way "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married b Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Divorced 4 Divorced Completed **Black** Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Voucher Examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Hawkins Annie Burroughs permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Stag Way Ft. Washington, MD. 20744 Mary C. Hawkins - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🖾 Buriai 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 1-23-2010 Brentwood, Md. 21. Signature of Euneral Service Licensee 22 Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final fnysician/ ATHEROSCLEROTIC CARDIOVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or se s conecquarios or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last bunialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death detached 9 Unknown Division of Vital Records, P.O. s been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ SEVERE DEMENTIA Completed 1 Yes 2 No 3 Probably 4 Unknown LESIGNS LIVER 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed ANEMIA this certificate 1 ☐ Yes 2 🖼 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖰 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No ☐ Accident within 24 hours after death

To the Funeral Director: / Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 20th 2010 53782 PHYSILIAN JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH VERGHESE 11701 LIVINGSTON READ, SUITE # 101, FORT WASHINGTON, MD 20744 M.D

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 0 2010

ark

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Januar Physician/ Derek J. Hilliard 11346A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince Georges Lanham Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 € M 2 □ F Washington, D. C. Director Jan. 577-74-2318 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Lanham 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 United States 8803 Groton Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 😿 No If Yes, Give 1 ☐ Yes 2x No Specify. Specify: Black Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Computer Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Hilliard Hazel Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20706 8803 Groton Ct. Lanham, Md. Hazel V. Bennett / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 1/20/2010 Harmony Memorial Landover, Md. 22. Name and Address of Facility Alexander S. Pope, P.A. 5538 Marlboro Pike/ Forestville, Md. 21. Signature of Funeral Service Licen e 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 MEARCION Physician/ wit MYOCAM DIAL disease or condition Medical resulting in death) Examiner AGUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in doubt). Lect Examine sician and burial-transit ITTE Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Nown been si shoutd b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed his certificate hil director, page 1 ☐ Yes 2 ☐ No 2 5 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Tes 2 No 1 Lapatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nume Practioner: To the best of my includes occurred at the time, date and place, and due to the cause(s) are manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 010 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add GOOD LUCK ROAD Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 9 2010 Registrar

		_	Please	Type or Prin				c. Ensure A Health and I	-	_	ible.		
		For State Registrar			,	•	tificate of		,	Reg. No. 2	110	02	542
Physici	an	1. Decedent's Name	(First, Middle, La	,					2. Date of De	eath _Day_	Year	3. Time o	of Death
/Medi		Brian		Keith	<u> </u>	lobell				27	10	100	18 M
Examir	ner		Milnor A	re street and number)				or Location of Deatl berland	n		ty of Death		
Funeral		5. Social Security Nu	ımber 6. S	Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi			nplace (State untry)	or Foreign
Director		214-80-	9390	□ x M 2□ F	41	Yrs.	Months Days	Hours Min.	Sep	3, 1968	Col	MD	
land ow		Usual Residence of I	Decedent 10b. County		10c. City,	Town or Loc	cation					10d. Inside C	City Limits
Mary a-f she	tor	MD	Alleg	gany		Cur	mberland	1				1 □Xes	s 2 No
ith the or 28;	Director	10e. Street and Num			1		10f. Zip Code			10g. Citizen of		-	
be filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Eventional matter collicial.	eral		Milnor A			140.4	V - B	21502		14.5	USA		
fter de	Funeral	 Marital Status Never Marrie 	ed 2 Married	12. Was Decedent I Armed Forces? 1 □Yes 2 □	Ever in U.S. No			Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	D- 14. H	ace - Amer ack, White,	ican Indian, , etc.	
ours a'	by	3 Widowed		If Yes, Give Year or Dates:		1	□Yes 2□ X o	Specify:		Spec	ify: V	vhite	
72 hc	Completed	(Speci	15. Decedent's Ed fy only highest gra	ducation ade completed)		(Give I	lent's Usual Occu	during most of wor	king	16b. Kind of	Business/Ir	ndustry	
within iene.	dwc	Elementary/Secon	idary (0-12)	College (1-4or 5	i+)	roofe	OO NOT use retire > r	ea)		Hite	Roofi	ng Co.	
e filed al Hyg other	Be	17. Father's Name (/	First, Middle, Last)		10010	· ·	18. Mother's Nar	ne (First, Middle	·		<u>g</u>	
lal ylallo Z IZ should be filed with and Mental Hygiene. Is marked other than aumatic event, Inc.	일	Robe	ert E. Ho	bell					ira D. (B				
VICII 12 sho h and 7 Is ma traume		19a. Informant's Nat Billie H	me/Relationship (Type. Print) wif	e	19b. Mailin	g Address <i>(Stree</i> 604 Miln	et and Number or Ru N O r AVENU 6	ıral Route Numb	oer, City or Town Imberlar	n, State, Zi 1d	ip Code) MD 21	1502
Pages 1 and 2 should be filed within 72 hours after death with the Marylan Pages 1 and 2 should be filed within 72 hours after death with the Marylan tent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or items 23a or 28a-1 show no other traumatic event, the Medical Eveniver must be retilled at		20a. Method of Disp		••••	20h Plac	ce of Disnos	sition (Name of		Date	20c. Location			
mit. Pages partment of cortant: If it / Injury or o		1 ☐ Burial 2 ☐		Removal from State	Sca	rpelli F	natory or other pla uneral Hor	ne, P.A.	1/28/201	Cre	sapto	wn	MD
partification of permit. Pages 1 and 5 Department of Health Important: If item 27 any Injury or other fr once.		21. Signature of Fur				22	. Name and Addi	ess of Facility Pelli Funeral I	Home, PA	<u> </u>			
D KOERA		VII	1///				108	Virginia Aven	ue: Cumbe		21502		
		23a. Parm. Enter th shirck, or hear Immediate Cause (F	t failure. List only	plications that caused one cause on each lir	the death. ne.	Do not ente	er the mode of dy	ring, such as cardia	or respiratory a	arrest,		Approxima Interval Be Onset and	etween
Physician/Medical		disease or condition resulting in death)	1	a. Self-:			unshot v	vound to h	nead		-		
Examiner		Convention list con	ditions	h =									
ed sit	iner	cause. Enter Under Cause (Disease or in	nacieta	Due to (or as	a conseque	nce of:	_		_				
be executed sician and burial-transit	Examiner	that initiated events resulting in death) La	-	cDue to (or as	a conseque	nce of):							
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			l	d									
leath certificate be attending physic if or use as the b	Physician/Medical	IF FEMALE:		-									
attend for use	lan/	23b. Was decedent in the past 12 r		23c. If yes, outcome	2 Fetal d	eath 3	Ectopic pregnar	псу			ate of deli Month	very Day	Year
the de	ysic	1 □Yes 2 □ 9 □ Unknown	lNo	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	atn 5∟	Other (specify)						
signed by the a	by Pt	Part II. Other signific	cant conditions	contributing to death b	ut not resulti	ng in the un	derlying cause g	iven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of	death?
w require s been signature									1 🗆	Yes 2 □ No	3 Pro	obably 4	Unknown
has be	ompleted								24a. Was	psy	prior to c	topsy findings completion of	s available cause of
Ital The I	O									ormed? 2 No	death? 1 ☐ Yes	2 □No	
Attending Physician: r death. ector: After this certific by the funeral director; by the funeral director; i	o Be	25. Was case referre examiner?		Hospital:	ent 2 ☐ Ef	2/Outpation	, 317 DOA 01	26. Place of Dea	ath <i>(Check only</i> Iome 5 ☐ Res		thor (C		c ival
g Phy ter thii	II— D	27. Manner of Death		28a. Date of Inju	iry 2	8b. Time of Injury	28c. Inju			how injury occu		my) [] Five	- way
rendir eath. or: Af	catic	1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigation 6 ☐ Could not b	1/27/10		0010		Yes 2 100	GUN :	SHOT W	orno	70 1	HEAT
or Att or Att of Atter d Sirect in by i	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined		ury - At home c. <i>(Specify)</i>	e, farm, stre	eet, factory, office		City or To	(Street and Nun wn, State)			
spital ours a neral [29a. Certifier	1 ☐ Certifying PI	NIVE nysician: To the best		y - A - edge, death				MINOT e cause(s) and			/- UP
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	edical	(Check only one)	Medical Exa	miner: On the basis o and manner sta	f examinatio	n and/or inv	estigation, in my	opinion, death occu	urred at the time	, date and place	e, and due	to the cause	(s)
To th	ž	29b. Signature and t	itle of certifier	Val			29c. Licer	nse number		29d. Date sign			
		1	Duc		puty M	-		157		01/27	7/201	U 	
				completed cause of d	·		,		502				
Sta	ite	31. Date filed (Mont)	11—Snow M. h, Day, Year)	32. Registr	3rd St ar's signatur	reet.	Cumberla	and, MD 21	JUZ				
Registi	ar	FER (75 5010	Rever	p. A								

	1	For State Registrar	•	Certificate	of Health and IV of Death		g. No. 2	1 0264
		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		Patricia Ann	Hughes			Januar		
Examin		4a. Facility Name (If not institution, give street and numb	er)		vn, or Location of Death		4c. County of Dea	
		24800 Pealiquor Road	Age (In yrs. last bir	Den thday) If Under 1 Y		8. Date of Birth	Carolir	I C thplace (State or Forei
Funeral		1 □ M 2 🕏 F			ays Hours Min.	Month, Day,	Year) _C	ountry) Laware
Director		213-42-1011 The superior of Decedent				August 10	1930 18	
/land		10a. State 10b. County	10c. City, Towr	or Location				10d. Inside City Limi
filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exant with our boundified a	żo	Maryland Caroline		Denton				1 □ Yes 2 🔯 N
7.28 1.28	Directo	10e. Street and Number		10f. Zip Co	ode	10	g. Citizen of What C	ountry?
23a c		24800 Pealiquor Road			1629			es of Ame
ems	Funeral	11. Marital Status 12. Was Decede Armed Force	es?	13. Was Deceden If Yes, specify	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
or it	F.	1 ☐ Never Married 2 ☐ MMarried 1 ☐ Yes 2	No X No	1 □ Yes 2 X	No Specify:		Specify: C	nucasian
ural"	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date		. Decedent's Usual C	occupation .		16b. Kind of Business	
n 72 "mat	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give kind of work of life, DO NOT use i	done during most of work retired)	ing		
with	E O	Elementary/Secondary (0-12) College (1-4	or 5+)	omemaker/	Teacher		Home/Educ	ation
I Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N		_
Aenta Aenta rked tic ev	To B	William Clagett		Donoho	Blanc			rkman
gas 1 and 2 should be liled within 72 hours after death with the wayran at of Health and Mental Hyglene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Evantinal rust by multihad at	-	19a. Informant's Name/Relationship (Type. Print)		_	Street and Number or Ru			
m 27 i		Harry R. Hughes Husb			iquor Road,			
of He of He fiten		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from St	210	of Disposition (Name ery, crematory or other	- 1		20c. Location - City o	
Fag ment ant: 1 ury o		4 □ Donation 5 □ Other (Specify)	Famil	y Cemeter	- 1		Denton, Ma	
permit, rages I an Department of Heal Important; If item 2 any injury or other once.		21. Signature of Funeral Service License			Address of Facility Mo h Second St			
Physician /Medical	6 3	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death) Due to (of	as a consequence		of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Deatl
physician and street transit street burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	r as a consequence	of):	DIJEA/C			Mary Yin
ueaur ceru e attending id for use a	Physician/Me	23b. Was decedent pregnant 1 Live bi	ome of pregnancy rth 2 □ Fetal death ant at time of death wn	h 3			23d. Date of o	elivery Day Year
ned b deta	by Pt	Part II. Other significant conditions contributing to dea		in the underlying cau	se given in Part I.	23e. Did tol	bacco use contribute	
been signed to		MARKINIONS 10	i/ATVd.	Denwi	19	1 □ Ye	es 2 No 3	Probably 4 ☐ Unkr
iaw requires titat the as been signed by th 2 should be detache	Completed					24a. Was a	an 24b. Were	autopsy findings avai o completion of cause
<u>o</u> — d	l mo					perform	med2 death	? es 2 No
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<u>~</u> .≌ :ē	To B	examiner? 1 Yes 2 No Hospital: 1 In	patient 2 ER/O	Outpatient 3 DOA	Other: 4 Nursing F		ence 6 Other (S	pecify)
anng rm h. After th funeral	<u>:</u>	27. Manner eath 28a. Date o	f Injury 28b. a, <i>Day, Year)</i>	Injury	c. Injury at Work?	28d. Describe he	ow injury occurred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of buildin	of Injury - At home, f g, etc. (Specify)	M farm, street, factory, o	1 ☐ Yes 2 ☐ No	28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the barrian (Check only one)	best of my knowledgesis of examination a er stated.	ge, death occurred a and/or investigation, i	t the time, date and plac in my opinion, death occ	e, and due to the ourred at the time, o	cause(s) and manned date and place, and c	as stated. lue to the cause(s)
ithin 2 o the	Med	29b. Signature and little of certifier	2	29c.	License number	2	29d. Date signed (Mo	pth, Day, Year)
5 ₩ ₩ CO			1	1	3/0//		1/27 /	10
	UI.	30. Name and address of person who completed cause	may /n	Time Balan	111706	10.00	1100/	
		Ludwig Eglseder, III, M			rive. Easta	on, Marvl	and 21601	

DHMH 17 Rev 1/2001

					d / Depa		Health and	Mental Hy	giene 0 0	02644
	Physicia /Medic Examin		Decedent's Name (First, Middle, Last) SHARON RENEE HARRIS					2. Date of Dea	ath	3. Time of Death 10:40A M
7			4a. Facility Name (If not institution, give street and numbe PRINCE GEORGES HOSPITAL	4b. City, Town, or Location of Death CHEVERLY, MARYLAND			4c. County of Death PRINCE GEORGES			
	Funeral Director		579-96-0731 1 M 2 X F 43 Yrs. Months Days					8. Date of Birt (Month, Day JAN. 1	th y, Year) 9. B 7, 1966 M	irthplace (State or Foreign Country) ARYLAND
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatly and Mental Hygiene. Depertment of Heatly and Mental Hygiene. Important: If them 27 is marked other then "natural," or iteme 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be motified at once.	tor	Usual Residence of Decedent		, Town or Lo					10d. Inside City Limits 1 XYes 2 No
		Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3416 KER DRIVE 20746 UNITED STATES							
Baltimore, Maryland 21215-0036		by Funeral	11. Maritat Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give 1 Yes or Date	☑No			Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nencan Indian,
		Completed	Elementary/Secondary (0-12) College (1-4of 5+)			dent's Usual Occupation I kind of work done during most of working DO NOT use retired) PROCESSOR			16b. Kind of Business/Industry LEGAL	
		To Be C	17. Father's Name (<i>First, Middle, Last)</i> LEMUEL THOMAS				18. Mother's Name (First, Middle, Maiden Surname) GEORGIA L. GROSS THOMAS			
			19a. Informant's Name/Relationship (Type, Print) GEORGE HARRIS/HUSBAND						er, City or Town, State, RYLAND 2074	
			20a. Method of Disposition 14 Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other (Specify)			sition (Name of matory or other pla ORTAL, CFMF		Date 23/2010	20c. Location - City of SUITLAND,	
Baltin	permit. Pepertm Depertm Importar eny injur		21. Signature of Funeral Service Licensee LYDIA C. THORNTON JOHN	ISON MC	22 TH 00583 34	2. Name and Addr HORNTON .39 LIVIN	ess of Facility FUNERAL H	OME, P.A	AN HEAD. M	D 20640
d	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Immediate Cause (Final MTTACTATTC RDDACT CANOTD								rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or	Due to (or as a consequence of):						
,09,	To the Hospitel or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death. Within 24 hours after death. In the Funeral Director: After this certificate has been signed by the elterating physicien and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner								
P.O. Box 687			on the past 12 months? 1 ☐ Ves 2 [X] No 4 ☐ Pregnant	23c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year	
rds, P		ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERICARDIAL METATASIS, PLEURAL METATASIS 1 Yes 2 No 3 Probably							
al Reco		Certification: To Be Complet	RESPIRATORY FAILURE, VENTILATOR DEPEN			1			psy prior to completion of cause of death? 2√□ No 1 □ Yes 2 ☒ No	
			25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpa	IL 3LI DOA	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			pecify)		
			1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury. At home, farm, street,		Work? M 1 ☐ Yes 2 ☐ No			18d. Describe how injury occurred 18d. Location (Street and Number or Rural Route Number,	
			4 Homicide determined 288. Place of Injury - At nome, building, etc. (Specify)			City or			Town, State)	
		Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		_	29b. Signature and title of certifier			29c. License number 200026026			29d. Date signed (Month, Day, Year) 01/18/2010	
15	3 10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LESTER MILES, MD, 1160 VARNUM STREET, N.E., WASHINGTON, DC 20017							
	Sta Registr		10000111 0040 1 6							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 13, 2010 **Physician** 6:20 Αм Dorothy Mae Harvey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Golden Living Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2√2 F Feb 7.1918 Maryland Director 91 220-03-4156 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Expriner mast be reathed at 1 XYes 2 No Director Frederick Emmitsburg MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21727 Funeral 58 Federal Ave. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2€ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☑ Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) ene. than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, ITM 1008. own home unknown Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Jeannette Alice Miller Emmett Augustus Wetzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2312 Sandel Lane Westminster, MD <u>Vicki Zimmerman Great Niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1/15/10 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Carroll Cremations, Inc. Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Ser 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. ule ack MD 21157 412 Washington Rd., Westminster, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** mos disease or condition resulting in death) /Medical ue to ur as a consequence of): Examiner rysele equaritimy flot canditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical the IF FEMALE: for use a 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) completely and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 MJL address of person who completed cause of death (Item 23a) (Type, Print)

W. Middlitm M.D. & S. Four 31. Date filed (Month, Day, 32. Regiştrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

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Box 68760 PO

Physician Month Day Annuary 13, 2010 1552		Please Type or Print in Black Indelible Ink. Ensure All Copies A	_											
Physician Medical Examiner Document Doc		Tor	2010 00010											
Donald Edwin Honeman January 13, 2010 1552		Decedent's Name (First, Middle, Last) 2. Date of Death Month	Day Year 3. Time of Death											
Dove House Dov	•	Donald Edwin Honeman January	13, 2010 1552 [™]											
S. Social Security Number Social Security	Examiner		· ·											
219-01-4360 Sept 26, 1919 Maryland Ma	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Birthplace (State or Foreign											
10a. State 10b. County 10c. City, Town or Location 10d. Inside City 10d. Inside City 10d. State 10d. County 10d. Inside City 10d. Inside City 10d. State 10d. City Code 10d. Zip Code	Director	219-01-4360 Sept 26,												
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	the deached the deached for th	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown 5 Other (specify)												
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24a. Was an autopsy performact? 1 Yes 2 XNO	has be e 2 sh	24a. Was an autopsy autopsy performs	24b. Were autopsy findings available prior to completion of cause of											
The state of Death (Check only one) 25. Was case referred to medical examiner? 4. Supplied to the state of Death (Check only one)	ifficate or, pag		No 1 □Yes 2 No											
25. Was case referred to medical examiner? 1	ysicia nysicia nis cert directe	examiner?	. mann linita											
27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Work? 28d. Describe how injury occurred Work?	ing Pt Affer th uneral	27. Manner of Death 28a. Date of Injury 28b. Time of Sc. Injury at Sec. Injury at Work? 28d. Describe how	v injury occurred											
1 1 2 2 3 Suicide 5 Pending (Month, Day, Year) Injury Work? 1 Yes 2 No No Yes 2 Yes 2 Yes 3 Yes 4 Yes	Vittend death ctor: / y the f	2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Bural Boute Number.												
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29a. Certifier (Check only Check on	Hospit 4 hour Funera tely fille	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dat												
29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	o the ithin 2 or the omple		d. Date signed (Month, Day, Year)											
1-15-10 D 5 1709 1-15-10	WIT	> Humowija, MD D51705	1-15-10											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAGAN PANSURIYA. 349 Malwim DR Westminster, MD 21157	ISHVA	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THAGAN PANSURLYA, 349 Malwim DR Westminster	MD 21157											
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature A. Spack		31. Date filed (Month, Day, Year) 32. Registrar's Signature												

DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma	aryland /	-	artment of F rtificate of I		Mental Hy	giene Reg. No.	2010	02647
			Decedent's Name (First, Middle, L.)	.ast)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		Albert W. Irion	, III					Januar	y 16°.	2010 ^r	9:35 P M
	Examin	er	4a. Facility Name (If not institution, g		md o o			Location of Death		i	County of Death	
	Francis		Casey House-Mont 5. Social Security Number 6.	0	pice e (In yrs. last bi	irthdav)	Derwood If Under 1 Year_	If Under 24 Hrs.	8. Date of Bi	th	ntgomer	place (State or Foreign
	Funeral Director		204-36-1539	1 ☑ M 2 □ F	61	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Col	intry) nsylvania
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	f shoved and and and and and and and and and an	ō	Maryland Montgor	nerv	Rockv							1 □Yes 2 ☑No
	r 28a-	Directo	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?
	h with		4920 Sunflower Di	cive			20853			Uni	ted Sta	ites
	r dear	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of H	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.))- 1	4. Race - Amei Black, White	
20	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Evaning must be notified at	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □ 1 □	[™] ietnam	1	1 □Yes 2k No	Specify:			Specify:	Thite
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7	led wii lygien her th		-	5+	Vi	ce_	President	18. Mother's Nam	· (Final Bridge)		FILI	
2	d be fil ental H ed otl	Be C	17. Father's Name (First, Middle, La Albert W. Irion					Edna Mo		, maiden s	Surname)	
2	should nd Me mark matic	၉	19a. Informant's Name/Relationship		19	b. Mailir	ng Address (Street			er, City or	Town, State, Z	ip Code)
Ĭ.	and 2 alth a 127 is er trau		Maureen Irion	(Spouse)	4	920	Sunflowe	r Drive,	Rockvi	11e,	MD 2085	53
5	es 1 a of He if Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3.	□ Removal from State	20b. Place o	of Dispo	sition (Name of natory or other place Heaven	e) Janu	Date ary 23,	20c. Lo	cation - City or	own, State
	t. Pag tment tant; jury o		4 Donation 5 DOther (Spe	¥69)		met	ery	20	10			ng, Maryland
ā	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygene. Important: If them 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fundal Service Lic		M00689)		2. Name and Addre Deast De		eVol Fu Drive,		-	g, MD 20877
			23a. Part 1. Enter the disease, or co	mplications that caused	the death. Do	not ent	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Lung Ca								Onset and Death
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200	icate t physic the b	edical		d								
YOU	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			-			2	3d. Date of deli	very
	death ne atte	Physician/M	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	y 			Month	Day Year
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	ding F h. After funer	tion:	27. Manner of Death 1⊠ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Date)		Time of Injury	Worl	yat ⟨? Yes 2 □ No	28d. Describe	how injury	occurred	
121	Atten r deat sctor; by the	ifica	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju	ury - At home, f	arm, str	eet, factory, office		28f. Location	Street and	d Number or Ru	ral Route Number,
5	tal or rs afte al Dire	Certification:	4 _ Homicide	building, etc	с. (Бреспу)				City or 10	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical		Physician: To the best of aminer: On the basis of and manner sta	f examination a							
	To the within To the comple	Me	29b. Signature and title of certifier	Park	ms		29c. Licens			29d. Date	e signed (Montl	n, Day, Year)
	30+1		J. Ko u act	inou,			263	140		Jar	nuary 17	, 2010
			30. Name and address of person wh Jocelyne Kouatch	o completed cause of d	eath (Item 23a) 6001 Mu	(Type,	Print) ster Mill	Rd., De	rwood.	MD 20	855	
	Sta	te	31. Date filed (Month, Day, Year)	39 Registra	ar's Signature			-				
	Registr	ar	JAN 19 20	10 Beaux	, A.,	Mar	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 10114 lanes 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND DEVLIN MANOR NURSING HOME If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 😿 F Director West Virginia 82 11/13/1927 216-24-4061 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or tiems 23a or 28a-f show any Injury or other traumatic event, the Training Examiner unstitue multiful at once. TYŽ Yes 2 ☐ No Director Cumber land MD **Allegany** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 Wallace Street 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify \$ Specify: **Black** 3XXVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Cole Homer Turner မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 226 Pear Street, Cumberland, MD louis A. Jones / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 01/19/2010 Flintstone, MD M.S.V.C. Rocky Gap 22. Name and Address of Facility
Upchurch Funeral Home, P.A.
202 Greene Street, Cumberland, 21. Signature of Funeral S vice Lice see 21502 RULL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nyveorde disease or condition resulting in death) morecute /Medical Due to (or as a o sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dué to for as a nonseque cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗐 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 ₩ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Boll ino

JAN 19 2010

DHMH 17 Rev 1/2001

Nat 1

32. Registrar's Signature

29c. License number

0017565

OD

2121e

29d. Date signed (Month, Day, Year)

n. 14,2010

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 12, 1:45 p Marianne Dellatorre Joly 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death 11012 Luxmanor Road North Bethesda Montgomery . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1955 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 VX District of Columbia Director 577-78-3273 Yrs 54 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Montgomery North Bethesda 1 Tes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 11012 Luxmanor Road 20852 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Examiner Black, White, etc ò þ 1 Never Married 2 Married 1 Yes 21 If Yes, Give Year or Dates. 2**X** No hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any righty or other traumatic event, the Megonee. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Family Physician Medical. 5 +Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl Michael Dellatorre Mary Vincenzia Carpineti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Michael Joly / Husband 11012 Luxmanor Road, North Bethesda, MD 20852 20a. Method of Disposition January 18, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2010 Silver Spring, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, 150 23a. Part 1. Enter the disease, or complications wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Failure disease or condition Medical resulting in death Due to (or as a consequence of) Examiner Gastric Cancer 1 year Sequentially list conditions, if any, leading to immediate cause. Enter chaorying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 Yes 2 No 2 X No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) မြ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of After 1 28d. Describe how injury occurred injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67823 January 15, 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21231 Aditya Bardia, 1650 Orleans Street, Johns Hopkins University, Baltimore, MD

State

Registrar

31. Date filed (Month, Day, Year)

19

arked

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 2010 SADIE JOHNSON 00:12A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Hours SOUTH CAROLINA Director 286-26-5789 90 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD PRINCE GEORGE'S RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 23a Funeral 4409 EAST WEST HIGHWAY 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 5 Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: BLACK "natural", 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 4 YRS TEACHER **GOVERNMENT** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 PERRY W. SMITH ROXIE AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT G. SMITH/NEPHEW 9106 HUNTINGTON COURT #X-1 LAUREL, MARYLAND 20708 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 1/20/2010 RIVERDALE, MARYLAND Singature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ,₽hysician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a continuous off burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Pregnant at time of death 5 Other (specify) 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 💢 Inpatient 2 □ ER/Outpatient 3 □ DOA After this Certificate: 27. Manner of Death 28a. Date of injury 28h Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Investigation 24 hours after death.

Funeral Director: A 1 Yes 2 No Accident the Suicide Could not be In by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined pleted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

within 2.

To the F
complet

State Registrar

DHMH 17 Rev 7/2009

address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 8 per F.D. 01/20/2010 Carroll County, will

For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Helen Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Joseph Medical Baltimore Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1919 1 M 2 XF 90 Months Days Hours Min 408-36-4169 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No TN Washington Grav 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 37615 705 Boone Station Road USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced White Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Nurse VA Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Blanche Charles Burton Propst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Shirley Anne Steel - Sister 32 Goucher Woods Court Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 16,2010 Johnson City, Monte Vista Cem. Funeral Service Licens 21. Signature 22. Name and Address of Facility & Crematory, Burrier-Queen Funeral Home 1212 W. Old Liberty Road inter the disease, or complications that caused or heart failure. List only one cause on each line. is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock Imm iat Cause (Final Physician/ di ease condition re ultir in death) SEPSIS Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed MYOCARDIAL INFORCTION and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death signed by the a a Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by enal Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🚺 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Dat signed (Month, Day, Year) WJL 024034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 8 0 NAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State	of Maryla	and / Depa		t of H	ealth		lental Hy		20	10	02652	
Physicia		Decedent's Name (First, Middle Angela Eckenrode	,							2. Date of De Month January	ath		Year	3. Time of Death	
Medic Examin		4a. Facility Name (if not institution	n, give street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4	c. County	of Death		
		Manor Care-Chevy	Chase			Che	vy Cha	ase				Mor	tgomer	.y	
Funeral Director		5. Social Security Number 219–30–1739	6. Sex 1 ☐ M 2 🕇 F	7. Age (In yr.	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bir (Month, Da April 4,	th ^{IV,} 190	8	9. Birthpl Count	lace (State or Foreign ry) Maryland	
od now	١	Usual Residence of Decedent 10a. State 10b. County	,	100	City, Town or Lo	cation							1/	Od Incido City Limite	
arylan a-fsh ffied a	Director	Maryland	Mon topmery	100.	Silver Sp									0d. Inside City Limits 1 ☐ Yes 2 1 No	
or 28	ä	10e. Street and Number				10f. Zip	Code				10g. C	Citizen of \	What Count		
s 23a rust b	Funeral	2201 Colston Dr:	ive, #310				20910				US	A			
death item		11. Marital Status	Armed F	cedent Ever in	U.S. 13. V	Vas Deced	ent of His	panic Ori	gin? (Spe	cify Yes or No- Rican, etc.)			e - America k, White, e		
after al", or xami	d by	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1 🗌 Yes If Yes, G	2 No live		Yes							White	ic.	
hours natura ical E	lete	15. Decede	nt's Education		16a. Deced	lent's Usua	l Occupa	tion			16h		wnice usiness Ind	ustry	
in 72 e. nan "r	Completed	(Specify only high Elementary/Seconday (0-12)	est grade complete College		(Give I	kind of wor O NOT use	k done di retired)	uring most	t of worki	ng	1		y Coun		
t with ygien her th	a l			(1-4 or 5+) 5 +	Tea	cher						hools			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	70 B	17. Father's Name (First, Middle, William Francis I	,							e (First, Middle, eve Bos w		n Surname	e)		
should and N is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	er or Rura	l Route Numbe	er, City c	or Town, S	tate, Zip C	ode)	
ind 2: lealth im 27 her tr		Robert Michael Kul	ns/Son					ad, S	ilver	Spring.	MD 2	20901			
ge 1 and to fit to or other		20a. Method of Disposition 1 █ Burial 2 ☐ Cremation	3 Removal fro	m State	Place of Dispo cemetery, cren	natory or o	ther place		Jan.	15,	20c. l	Location -	City or Tov	wn, State	
iit. Pai artmer ortant injury		4 Donation 5 Other		Joseph'				2010)	L		, Mary	land		
permi Depar Impor any ir		21. Signature of Funeral Service	Licensee/	20	- 1					eral Hom					
	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx													O1 Approximate	
Physician/	ian/ Immediate Cause (Final disease or condition Find-Stars Cardiac Disease													Interval Between Onset and Death	
Medical Examiner		resulting in death)	Due to	o (or as a conse	equence of):										
	Je	Sequentially list conditions, If any, leading to immediate b. Congestive Heart Failure Due to (or as a consecutaring of)													
rted d ansit	Examiner	Sequentially list conditions, if any leading to furnished cause. Enter Underlying Cause (Disease or injury													
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attending p for use as t		IF FEMALE:	23c. If yes, or	utcome of preg	nancv										
eath c atten for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 🔲 Liv	e Birth 2 🗆 F gnant at time o	etal death 3 🗌	Ectopic p Other (sp		<i>'</i>				23a. Da Mo	te of deliver nth (ry Day Year	
t the death	hys	9 🗆 Unknown	9 □ Uni							_					
v requires that to been signed be should be deta	ል	Part II. Other significant conditi	ons contributing to	death but not i	esulting in the u	nderlying o	ause give	en in Part I						e cause of death?	
equire een si nould l	sted									1 🗆	Yes 2	2 □ No	3 L Prob	ably 4 American	
has b	Completed						-			24a. Was auto		1 1	Nere autop: orior to com death?	sy findings available apletion of cause of	
sician: The la certificate ha irector, page à		25. Was case referred to medical					00 51	(5)	1 (0)	1 🗆 Yes			I ☐ Yes 2	2 □ No	
rsician: s certific director,	To Be	examiner? 1 Yes 2 No	Hospital:	Innationt 2	☐ ER/Outpatien	+ 2 \(\sum_{\text{DC}}\)	Othor	ce of Deat			1	6 D 04h	(016)		
g Phys er this neral di	ë	27. Manner of Death	28a. Date	e of injury nth, Day, Year)	28b. Time of		Bc. Injury	at		me 5 Resident					
endin eath. or: Aft he fur	fica		gation	iiii, Day, reai)	injury	М	work?	′es 2 □	No						
or Att after d Direct in by t	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Plac	e of Injury - At ding, etc. (Spec	home, farm, stre	et, factory	office			28f. Location (S City or Tox			er or Rural f	Route Number,	
spital nours neral I		29a, Certifier 1 K Certifying	Physician: To the	best of my kno	wledge, death o	ccured at	the time.	date and	olace, and	d due to the ca	use(s) a	ind manne	er as stated		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical	(Check 2 Medical I	xaminer: On the ba Nurse Practioner	asis of examinat	tion and/or invest	igation, in r	ny opinior	, death oc	curred at	the time, date a	and place	e, and due	to the caus	se(s) and manner stated.	
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30		7					D.	54566 			Jan	uary :	11, 20	ľΛ	
		30. Name and address of person Sunitha Bhogavi			em 23a) (Type, P rgia Aven		-17,	Silver	: Spri	ng, MD 2	0902	!			
State	-	31. Date filed (Month, Day, Year)	2010 32	Registrar's Sign	A. Sa										
Registra	r	JAN 14	2010	un	p. 190	Vien	4								

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARGARET KLUTCH E. 2010 January 2:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Mar. 9, 1944 Min. 066-36-3291 65 Hours New York Director Usual Residence of Decedent If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1032 West Side Drive 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry feeth and Mental Hygiene.

m 27 is marked other than "n.

er traumatic event "h." (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Assistant Prescription Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Maiello Julie Vaccariello 1 and 2 should to the set of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Christopher Klutch (Son) 3041 Clarks Corner Road, Marathon, New York 13803 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 14, Jan. 4 ☐ Donation 5 🏿 Other (Specify) Entombment 2010 Silver Spring, MD Gate of Heaven 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home Teette 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 13 Days Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Multisystem organ failure 13 Days Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin and I-transit Surgery (small bowel resection) 13 Days To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Type II diabetes, has been sig 1 Yes 2 X No 3 Probably 4 Unknown Chronic renal insufficiency 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? certificate ha lirector, page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Kim MD 31. Date filed (Month, Day, Year)

JAN 14 2010 🙎 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margaret R. Komatz 8, 2010 3:05 P M January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS-Frostburg Nursing & Rehab Center Frostburg Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 15, 1921 9. Birthplace (State or Foreign Months Days Hours Min. West Virginia 213-24-6348 88 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1/12 Yes 2 □ No Allegany Maryland Frostburg 10e. Street and Number 10601 Komatz Drive 10f. Zip Code 10g. Citizen of What Country? 21539-USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Airhart Edith Kasecamp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Knotts daughter 10614 Lomatz Drive 21539-Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Restlawn Memorial Gardens January 12, 2010 Cumberland Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Il any, teaching to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 1□Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

traumatic

Item 2

Department of Important: If It any Injury or o

Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 2

Baltimore, Maryland 21215-0036

Director

Funeral

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The law requires that the death certificate be executed burial-transi the as ding

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be

Examiner

Medical Certification: To After

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

or Attending death. nours after death.
neral Director: / within 24 hours a

To the Funeral C

completely filled i To the Hospital

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State Registrar Sidnu

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to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) TANGARY 08, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh Rd Cumberland, MD21502

31. Date filed (Month, Day, 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth Rosalie Louise Kegg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Regional Med. Ctr. Cumberland Allegany Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 TyPF Director 220-32-4489 72 2/23/1937 West **Virginia** Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11513 Valley Road, 21502 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Seamstress Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Earnest White Sadie Katherine McMannis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Collins / Daughter 12309 Shadoe Hollow Road, NE, Cumberland, 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 01/17/2010 Cumberland, MD Signature of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home, 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ disease or condition Medical resulting in death) Examiner RS HEONIC BRSTRUCTIVE LUNC DISCAS STAGE dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death Day detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has certificate 1 Yes 2 No 24 hours after death.

Funeral Director: After this certifical eted filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗖 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number TH 2010 3

Registrar
DHMH 17 Rev 7/2009

State

71 Rs

M.D.,

Jr.,

Registrar's Signature

21502

200 Glenn Street, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Robustiano J./Barrera,

31. Date filed (Arti Dy, Aear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician. 2 ABETH KEHOE Month 2010 2100 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6911 Heidelburg Road Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗷 F Months Days Hours June 14, 039-12-8694 Director Newport, RI 1927 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Prince George's Maryland Lanham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6911 Heidelburg Road 20706 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o Mary Frances Murphy James A. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 6911 Heidelburg Road, Lanham, MD 20706 James W. Kehoe, Jr. / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 1/19/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Ray Rogens Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Pnysician/ disease or condition w Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) sician and burial-trans Exal Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 ed by the a 9 Unknown Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 si autopsy performe 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check det the time. Certifying Nurse Practioner: To the Lest of my knowledge 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) HIGHWAY ANNAPOLIS MO ZIYUL 744

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 02657 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eugene Harvey Kipp, Jr. Month Day Year 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Country)
Texas Days 1 🔯 M 2 🗆 F Months Hours Director 465-07-6785 87 Usual Residence of Decedent shov 10b. County 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1200 Oakhill Place, Apt. 2A 21403 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces 1 ☑ Yes 2 ☐ No If Yes, Give 1943-71 Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Army Officer U.S. Army 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Harvey Kipp, Theresa Greer Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 1 and 2 shound Health and item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Kipp/daughter 1200 Oakhill Place, Apt. 2A Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery 2/19/2010 Arlington, Virginia 21. Signature of Funeral ervice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate causa. Error Undarying Cause (Disease or iinjury Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Division of Vital Records, or Attending Physician: The law requires 2 No 1 Yes 3 Probably 4 Unknown been si should I COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 L Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 I DOA this 27. Manper of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu Accident 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

January 15, 2010 29b. Signature and itle of certifier D0063145

State

Registrar

LIVA

705 Digital Drive, Suite G Linthicum, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Arvind Desai

31. Date filed (Month, PAN 15 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 11:00P.M Hillard Knight, Sr. Morris 19 JANUARY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeder's Memorial Home Washington Boonsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Year) Hours Months Days July 21,1925 Director 84 Maryland 219-14-8092 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show injury or other traumatic event, the Wadical Examinar must be notified at 1 ☐ Yes 2 XNo Director Washington Sharpsburg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō items 23a 21782 USA 2230 Back Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married then "natural", or 1 □Yes XX No Specify: Specify. δ ₩Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Brakeman Railroad and N ental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward M. Knight <u>Elsie Mae Myers</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 2230 Back Road Sharpsburg, Maryland 21782 Morris H. Knight, Jr. - Son 20a. Method of Disposition
1 □ Burial 2 🕍 Cremation 3 □ 5
4 □ Dovation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Bernoval from State Smithsburg Crematory Jan. 22, 2010 Smithsburg, Maryland Osborne AFunerally Home, P.A. 21. Signature of Funeral Ser 425 S. Conococheague St. Williamsport, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Advances /Medical Due to (or as a consequence of): **Examiner** appearing Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 0 4 Pregnant at time of death 5 Other (specify) □Yes 2□No the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed certificate 1 □Yes 2.2 No 1 ☐Yes 2, ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760,

 $ME: extit{KTCH7}, SR., IM$ Baltimore, Maryland 21215-0036

old be f

death certificate be Division of Vital Records, Attending Physician:

within 24 hours a the Hospital VH-1

State

death.

29a. Certifier

(Check only one)

Medical

29b. Signature and title of certifier

Mn

29c. License number 03251

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301-432-2222 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756 ROBERT GUEDENET,

31. Date filed (Month, Day, Year) JAN 22



Registrar

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	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Evertiner must be notified at	Funeral	11. Marital Status		Arme	Decedent I ed Forces?		S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic (an, Mexic	Origin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A	merican Indian, hite, etc.
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İSİ	Attend death ctor: /	fica	2 ☐ Accident 3 ☐ Suicide	6 Could	not be 28e. F	Place of Inju	ry - At ho	me, farm, str			163 21		28f. Location	(Street ar	nd Number or	Rural Route Number,
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	Hospital 24 hours a Funeral I	Sal	29a. Certifier (Check only	1 Certifyi	ng Physician: T	o the best	of my know	wledge, deat	h occurre	ed at the tir	ne, date	and place,	and due to th	e cause(s	and manne	r as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one)		and	manner sta	ted.	uon and/or in	vestigati	on, in my o	pinion, a	eath occur	red at the time	e, date an	a place, and c	due to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 12:40p M Physician/ 2010 Florence Lewin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac Potomac 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, y April 09 5. Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Days Hours 1 □ M 2 🎗 F Months Director 051-14-1276 90 1919 Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🗓 No Potomac Montgomery Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20854 U.S.A. 10714 Potomac Tennis Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Completed 3 X Widowed 4 Divorced Caucasian Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James Lindenbaum Sylvia Redansky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 619 Blossom Drive. Rockville, Maryland 20850 Alexander Lewin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 a Department of H Important: If ite 1

Burial 2

Cremation 3

Removal from State Lincoln Crematory 01/16/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause n each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the Inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown Division of Vital Records, 2 No 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No death. Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

To the I within 2 To the 1 10

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

9

se of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wiscondin

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of	Maryland / D	epartment Ce <i>rtificat</i> e				giene /	2010	0266	
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	State	31. Date filed (Month, Day, Yea	r) 32/Reg	gistrar's Signature	1		300	HOILII WC	me ot	, waitiiii	J. C, 111D, 2.12C	-
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be completely filled in by the funeral director.	Medical Certification: To Be	25. Was case referred to mediexaminer? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Per 2 Accident inve 3 Suicide 6 Cou 4 Homicide dete 29a. Certifier (check only 2 Medione) 29b. Signature and title of cert	Hospital: 1 28a. Date of (Month, stigation lid not be building) lying Physician: To the base and manner iffer on who completed cause of the physician who cause of the physician who completed cause of the physician who cause of th	Injury Day Year) In Day Year) In In In In In In In In In In In In In I	me of jury M 28 28 28 28 28 29 28 29 29 28 29 28 28 28 28 28 28 28 28 28 28 28 28 28	A Other: 4 3c. Injury at Work? 1 — Yes office at the time, c in my opinion	4 Nursing I	28d. Describe to 28f. Location (City or Townson, and due to the curred at the time,	dence 6 how injury (Street and vn, State) cause(s) a, date and 29d. Date	and manner a place, and di	Rural Route Number, as stated. ue to the cause(s) th, Day, Year)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene / 1 - For State Registrar Certificate of Death Reg. No. gedent's Name (First, Middle, Last) 2. Date of Death Zonate of Zonation Day 2012

Tenuary 1 Zonath Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year APR. 30, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Min. Months Days Hours 1944 Virginia 65 Director 225-58-2633 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 XNo Director notified Windermere Florida Orange 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 5069 Isleworth Country Club Drive 34786 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. the Medical Examiner 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Caucasian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed Business Owner permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Howard LaRose Melba Craner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5563 Shawbrook Court, Haymarket, VA 20169 Michelle LaRose, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other pl Fairfax Memorial Funeral Home 20c. Location - City or Town, State Date 20a Method of Disposition JAN. 17, 1 ☐ Burial 2X Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 2010 Fairfax, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fairfax Memorial Funeral Home
9902 Braddock Road, Fairfax, Buin Miller M01508 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INTERCTION **Physician** Muscardia disease or condition /Medical resulting in death) Due to (as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 4 Unknown 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed 2 🗌 No 1 Yes certificate I or Attending Physician; after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Department Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roland Faciale 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature. State parke 19 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1M/107/20 PPYO Susan Juanita Lake 1750 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🏋 F 2^M/2¹1^D/1^Y9¹54 Country) WV. 232-92-4122 Director 55 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director WV Harrison Lumberport 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Box 336 26386 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene, item 27 is marked other than College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) Fay June Lakey 17. Father's Name (First, Middle, Last) Earl Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aleta Lake/Daughter P.O.Box 336 Lumberport, West Virginia 26386 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crem. 1/13/2010 Beltsville, Md. 5 Other (Specify) 4 Donation 21. Signature Funeral Service Line HOTSON AFUNERAL HOME 500 Fast Main Street Mannington, WV. 26582 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse mence of): Examiner heamone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury) Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last an/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Yes 2 No 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be

Physici	
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Completed by	
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Medical

29b. Signature and title of certifier

		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
5. Was case referred to cal	26. Place of Death (Che	ock only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA Other: 4 I Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
7. Manner eath 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ician: To the best of my knowledge, death occured at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occurred	

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00066100

29d. Date signed (Month, Day, Year)

Aymes

State Registrar

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD Universit 31 Date filed (/ 32. Registrar's Sig

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02664 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 13 3. Time of Death Physician/ Roger Law Jan. 2010 6:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8600 Mike Shapiro Drive # 803 Clinton Prince George's 8. Date of Birth
(Month, Day, Year)
Dec. 3, 1938 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F Months Hours Virginia Director 71 Dec. 206-32-7167 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8600 Mike Shapiro Drive 20735 United States ural", or items ? I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 A Widowed 4 Divorced "natural" Completed Year or Dates. the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If item 27 is marked other than 1 Elementary/Seconday (0-12) College (1-4 or 5+) 12th Entrepreneur Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Purcey Alphonso Law Ola Milner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Magnolia Drive Oxford, GA Tamara Garnett/Daughter Baltimore, t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State January 21. Landover, Maryland ☐ Donation 5 ☐ Other (Specify) Harmony Memorial <u> 201</u>0 2. Name and Address of Facility Stewart Funeral Home, Sig of Funeral Servi e Lice 4001 Benning Rd. NE 20019 Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final ₹hysician/ Metastatis Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) led by the a detached f 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 24 hours after death.

Funeral Director: After this certificate Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \sum Yes Other: 4 \(\to \) Nursing Home 5 \(\bar{\textbf{X}}\) Residence 6 \(\to \) Other (Specify) 2 EXNo 2 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiny 3 Certifying Nurs ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month) 0 20706 30. Name and addre

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 2010

Suite 100

8116 Good Luck Rd.

Lanham, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Lumpkin 2010 5:30p. Januarv Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Ft. Washington Health & Rehab Fort Washington 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/12/1914 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗗 F Months Days Hours Director 22 7942 95 North ["]Carolina Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director DC Washington 1 Tryes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7530 9th Street, NW Apt. S#1022 20012 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ♣ No Specify: Specify: Black "natural" 3 Midowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government of Health and Mental Hygie fitem 27 is marked other r other traumatic event, tt <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosa Horne G. Finch Bruton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3003 Van Ness St., NW Robert Lumpkin Washington, DC 20008 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1[™]Burial_2 ☐ Cremation 3 ☐ Remova cemetery, crematory or other place from State 4 Denation 5 Other (Specify) 01/15/2010 Washington, Olivet Cemetery signatur of Funeral Service Licensee 22. Name and Address of Facility John T. Rhines Funeral Home LLC 20017 3005 12th Street, NE Washington, DC a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease Sequentially list conditions. ary, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 27 No To the Hospital or Attending Physician. within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 13 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🔼 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar 29b. Signature title of certifier

Edgar Potter,

MD

11701 Livingston Road, #207

son who completed cause of death (Item 23a) (Type, Print)

32. Registar's Sign

29c. License number

D42955

29d. Date signed (Month, Day, Year)

Ft. Washington, MD 20744

January 14, 2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended #2perMD FCHD, KS 1/15/16 ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1. n Known Catherine E. Langbehn 2010 Medical Januarv 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1001 Carroll Parkway, Apt. Frederick # 311 Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 □X Oct. 26, Months Davs Hours Year) 1918 Pennsylvania 188-05-7494 Director 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Carroll Parkway, Apt. #311 21701 United States 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 x No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William F. Black Mary Dittenhafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Smith / Niece Veirs Mille Rd., Apt.#202, Rockville, MD 20853 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 1/8/2010 4 Donation 5 Other (Specify) Crematory Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Interval Between Immediate Cause (Final Onset and Death L'hysician/ disease or condition resulting in death) 4Theresc Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year a T IJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Hame 5 Residence 6 Other (Specify) Hospital: 2 2 10 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28c. Injury at work? 1 ☐ Yes Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural iniury 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certif 29c. License numbe 29d. Date signed (Month. Day, Year)

Registrar

State

31. Date filed (Month, Day,

's Signature

Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1 - For State Registrar		of Marylar		artment rtificate				Reg. No.	2010	02567
Physic	cian	1. Decedent's Name (First, Middle Elizabeth	,	xner					2. Date of Dea	Day	Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution				4b. City. To	wn, or Local	tion of Dea	January		2010 County of Death	8:12 A ^M
Exam	illei	16524 Redland R	-	,			erwood				ontgomer	cy .
Funera		,	6. Sex 1 ☐ M 2 🛱 F	7. Age (In yrs.		If Under 1 Months E	Year If Un Days Hou	nder 24 Hrs urs Min	. (Month, Da	th y, Year)	Cour	place (State or Foreign
Directo	r	051-28-0009 Usual Residence of Decedent		75	Yrs.				August	17,1	L934 Ne	w York
yland now at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	<u></u>				1	0d. Inside City Limits
e Mar 3a-f sl tified	Director	MD Montg	omery		Derw	rood						1 ☐ Yes 2 X No
filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Dire	10e. Street and Number			×	10f. Zip Co					en of What Cour	
eath v ns 23a must	Funeral	16524 Redland R		edent Ever in U	S 13	Was Dacadan	2085		Specify Vas or No		ited Sta 4. Race - Americ	
ifter d		11. Marital Status 1 □ Never Married 2 Marri	Armed Formed Fo	orces? 2 X No					Specify Yes or No rto Rican, etc.)		Black, White,	etc.
72 hours aft natural", or iical Exami	d by	3 Widowed 4 Divorced	If Yes, G Year or I	ive		1 □ Yes 2 □	No Spe	ecify:			Specify: Wh:	ite
"natu	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usual (kind of work (DO NOT use (Occupation done during	most of wo	orking	16b. Kin	d of Business/Inc	dustry
within iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	inte.	School				Edu	ucation	
the filed ental Hyg ced other c event, t	Be C	17. Father's Name (First, Middle, I	1		1		18. N	lother's Na	me (First, Middle,	Maiden S	Surname)	
Menta	10 E	James Regan					ŀ	E1i	zabeth D	ugan		
2 sho h and Is ma		19a. Informant's Name/Relationsh		•		-			Pural Route Numbe	-		Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Raymond P. Meix 20a. Method of Disposition	ner/Husb	. ,				ad, D	erwood,		ation - City or To	wn State
ages ent of it: If it		1 X Burial 2 ☐ Cremation		State	Place of Dispo cemetery, crei				uary 18		•	
permit. Pages 1 and 2 sh Department of Health and Important: if item 27 1s m any injury or other traum	ń	4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		ALL		2. Name and	Address of F	acility	010		mantown	
Departing any ir.	i i	TRACIA.	ruder	M0111	7 De	eVol Fu	ineral	Home	, 10 Eas	t De	er Park 20877	Drive,
Physician /Medical Examinet physician and the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Lunc Cancer Due to (or as a consequence of): c. Due to (or as a consequence of):										Approximate Interval Between Onset and Death
ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	tcome of pregna birth 2 □ Feta gnant at time of a nown	al death 3	Ectopic prec				25	3d. Date of delive	ery Day Year
w requires that the do s been signed by the should be detached	by P	Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the u	nderlying caus	se given in F	Part I.				he cause of death?
requires seen sign	eted				-				1 🗆 ١	Yes 2∟]No 3 <u>K</u> ∏ Prob	oably 4 🗌 Unknown
: The law icate has b ; page 2 s	Completed								24a. Was autop perfo 1 □ Yes	rmed?	prior to co death?	psy findings available mpletion of cause of 2 No
siclar certif	Be	25. Was case referred to medical examiner?	Hospital:				Other:		ath (Check only o			
g Phy er this eral d	1:1	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	28b. Time of		Injury at Work?	_ Nursing	Home 5 N Resident Resident Resident Page 1 28d. Describe I			(y)
ath. rr: Aft	atio	1 Natural 5 Pending 2 Accident investig		nth, Day, Year)	Injury	м	Work? 1 □ Yes	2 □ No				
크를들드	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 28e. Place	e of Injury - At he ling, etc. <i>(Specli</i>	ome, farm, str	eet, factory, of	ffice		28f. Location (S City or Tox	Street and vn, State)	Number or Rura	al Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical		Physician: To the xaminer: On the l									
o the	Mec	29b. Signature and title of certifier	and mar	iller stated.		29c. L	icense num	ber		29d. Date	signed (Month,	Day, Year)
10		1	3	/~	Cir	D	006243	35		Janu	ary 13,	2010
		30. Name and address of person v	vho completed cau	se of death (Iter	n 23a) (Type,	Print)	n Da	1 1 1	10 MD 24	 0.850		
		Sayed Aisayyad				r priv	e. KO	KVII.	re, mp 2	0000		
St Regist	tate trar	31. Date filed (Month, Day, Year)		Registrar's Signa	h ha	4.1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Orville Herbert Moore Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Çity, Town, or Location of Death 4c. County of Death egiond Cumberla Allegane ledica 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 80 212-24-1637 Director Pennsylvania 01/26/192 Usual Residence of Decedent Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Allegany 1 🗌 Yes 2 🔀 No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13800 Oxford Avenue, SW 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1950-Completed by Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 Widowed 4 Divorced Specify: White 1954 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Maintenance Tire and Rubber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Buchanan Moore Edith Pearl Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Moore / Wife 13800 Oxford Avenue, SW, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 01/19/2010 Cumberland, MD . Signature of uneral Service Licen 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. 23a, Part 1 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final Onset and Death Physician/ MAI disease or condition resulting in death) MON Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day Yes the Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has b autopsy performed? Yes 2 No death? 1 🗌 Yes 2/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: ြု 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director. After this certificate h
completed filled in by the funeral director, page To the I

> nas State

(Check

29b. Signature

31. Date filed (M

only one

nd title of

Qamar Zaman,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

2. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

54

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12502 Willowbrook Rd, Suite 440, Cumberland,

29d. Date signed (Month, Day, Year)

2010

21502

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald M. Mannick, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western Maryland Regional Medical Center Cumberland 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 X M 2 - F Davs Hours Min (Month, Day, Year) 74 Director 216-34-4326 Usual Residence of Decedent June 01 larv other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19313 Lower Consol Road Funeral U.S.A 21532 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?,

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) meat department manager grocery store any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Paul Michael Mannick Laura Cullen permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Mannick daughter-in-law 21742-22 Stanford Road Hagerstown Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory January 17, 2016 Cumberland Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Ent. the dilease, or complications that cursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Gastrointes disease or condition resulting in death) one dan Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**X** No 1 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar DHMH 17 Rev 7/2009

10

MRS

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Bishop

925

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mn

SHIN

		For State	State of Ma	aryland		artment of H		Mental Hy	giene2 ()	0 0 0 2 6 7 0
_		Registrar	o at)		Ce	rtificate of L)eath		Reg. No.	0.71
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/Medic		4a. Facility Name (If not institution, g	ive street and number)	-		4b. City, Town, or	Location of Death	101	4c. County of	
Examin		Brooke Grove Nur		b Cer	rter		Spring			lontgomery
Funeral		Social Security Number 6.			ast birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 1		
Director		579-42-7560 Usual Residence of Decedent	ILIWI ZEGIF	91	Yrs.			April 1	9,1918	9. Birthplace (State or Foreign Country) Russia
/land		10a. State 10b. County		10c. City	, Town or L	ocation				10d. Inside City Limits
a-f sh	ctor	Maryland Montg	omeru			Sil	ver Spri	na		1 ∑Yes 2 □ No
or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
s 23a	erai	15300 Walbrook Co					20906			I.S.A.
ter de item: iner.n	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 □ Yes 2 🛣		5. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Si n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Black,	- American Indian, White, etc.
72 hours after death with the Maryland natural", or items 23a or 28a-f show	by	3 🔀 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•		1 □Yes 2 🗓 No	Specify:		Specify:	Caucasian
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should be filed within and Mental Hygiene. I marked other than "umatic event, the Market of the Mark	To Be	Michael O	•				Tot Mouloi o Han	, ,	Schaedel	
shoul and M s mar umati	F	19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·		19b. Mail	ing Address (Street a	and Number or Ru			tate, Zip Code)
and 2: ealth a m 27 is		Victor R. Madof	k - Son		520	Garibaldi	Avenue.	Roseto.	Pennsul	Evania 18013
of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	20b. Pla	ace of Disp emetery, cre	osition (Name of matory or other place	9)	Date	20c. Location - Ci	ity or Town, State
t. Pages tment of tant: If its ijury or o		4 □ Donation 5 □ Other (Spec	cify)	Gate	206 t	leaven Cem	. 01/2	3/2010	Silver S	Spring, MD
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Imporbant: If item 27 is marked other than "natur any injury or other traumatic event, the Madical once.		21. Signature of Funeral Service Lo	ensde	143	7 11	2. Name and Addres 800 New H	s of Facility Hi ampshire	nes-Rind Ave., S	ıldi Fune Silver Sp	ral Home, Inc. Dring, MD 20904
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/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	1.4.				
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has t	Completed	HNEMIH, 1	10871C	57	ENC	12.17.		24a. Was a autop	sy pri	ere autopsy findings available or to completion of cause of ath?
in: Th ificate or, pag		25. Was case referred to medical						1 □Yes	2 □ No 1 □	atr: ☐Yes 2 ☐ No
ysicia s cert	o Be	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 E	-B/Outpatie	ent 3 DOA Othe	26. Place of Dea		ne) dence 6 ☐ Other	(Specify)
ng Phy ter thi	T:u	27. Manner of Death	28a. Date of Inju (Month, Day	ry	28b. Time o				now injury occurred	
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or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hor c. <i>(Specify)</i>	me, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	or Rural Route Number,
pital ours a leral C		29a, Certifier	Physician: To the best of	of my know	vledne dea	th occurred at the tim	e date and place	and due to the	cause(s) and man	ner as stated
To the Hospital or Attending Physician: The law requires that the death certity within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	f examinati	ion and/or i	nvestigation, in my or	pinion, death occu	rred at the time,	date and place, an	d due to the cause(s)
	Σ	29b. Signature and title of certifier	M. Lo	1		29c. License	number		29d. Date signed (Month, Day, Year)
10		Muller	Dolle	Uln	14.	1000	5 163	0	01 - 13	- 2010
		10301 CIEOR	o completed cause of di GIA	eath (Item	23a) (Type	SILVE 1	ADHA A	PRING	209	702.
Sta Registra		31. Date filed (Month, Day, Year) JAN 19 2	32 Registra	ar's Signat	le de	a del				
Negistra	·II	ONN 17 4	I Remark	1 /3	. 1990					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16,2010 Year **Physician** Maynard 1217 p^M Thurmond Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Prince Georges Hospital Cheverly
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Hours Months Days 242-80-8865 61 Director 10/25/48 Carolina Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be mained at 1 X Yes 2 ☐ No Director Ft. Washington MD Prince Georges Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or 28a 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 20744 12815 Pine Tree Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: unk. 1 ☐ Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Completed by Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Newspaper Distributor Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Motley ၉ Raymond Maynard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip $\overline{c_{
m Ode}}$ $\overline{20744}$ Evangerlene D. Maynard Ft. Washington, MD 12815 Pine Tree Lane 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wesley Chapel U
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State M.1/23/10 Reidville,NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility McLaurin Funeral Home wice Licensee cc0278 721 E Morehead St.Reidville,NC 27320 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit stely filled. Exami Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Completed Be Certification: To

24a. Was ar autopsy perform 1 □Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 □ No

25. Was case referred to medical examiner?
1 ✓ ves 2 ☐ No 27. Mapner of Death 1 Natural 2 Accident 5 Pending

28a. Date of Injury (Month, Day, Year) investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

3 □ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

person who completed cause of death (Item 23a) (Type, Print)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

24 hours a

To the l

Medical

31. Date filed (Month, Day, Year) JAN 2 0 2010

29b. Signature and title of-certifie

32. Registrans Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:25 AM our olun Herinator 01 2010 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Burtonsville
If Under 1 Year | If Under 24 Hrs. | 8. | Montoomer 5. Social Security Number + HOLY Cross 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Hours 1 □ M 2 X F Davs 224320789 Usual Residence of Decedent Director with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No be notified Director MID Howard olumbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or USA 7313 Little Bird 21046 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 'natural", or Specify Specify: 2 3 Widowed 4 □ Divorced Black Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) lerk Apartment Complex ia permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other i any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Khonda Thomas Arrington Thomas ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Gill Columbia, MD 21046

20c. Location - City or Town, State 1313 Little Bird Path 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Comfort Cem. 1-21-2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home any in once. 314 Franklin Street, Alexandria, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVA **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-trar and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1☐ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069829 Ween 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

JAN 2 0 2010

NAOVI.

2835 Smith Ave, Suite 203, Ballimone MD 21209

		Please Type or Print in Bla State of Maryland	/ Depa	rtment of He	ealth and N	-		gible.	
		1 - State Registrar	Cer	tificate of D	Peath	Re	g. No. 2	010	02673
Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	Day	Year	3. Time of Death
/Medic		Clema Louise Moreland				January			3:00 PM
Examin	ier	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or l				unty of Death	man! n
		Hillhaven Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. las	t hirthday)		elphi If Under 24 Hrs.	8. Date of Birth	PII	nce Geo	ce (State or Foreign
Funeral Director		205-26-8296 ^{1□ M 2⊠ F} 77	Yrs.	Months Days	Hours Min.	(Month, Day, June 29,		Country	stone, PA
to the second se		Usual Residence of Decedent				Julie 299	1752	GIIII	scone, IA
how at	_	10a. State 10b. County 10c. City, 7	Town or Loc	cation				100	d. Inside City Limits
e Ma Ba-f s	Director		ttsvi						1 X Yes 2 No
vith th		10e. Street and Number		10f. Zip Code	0701	11	-	of What Country	λ,
s 23a	Funeral	4114 Emerson Street 11 Marital Status 12, Was Decedent Ever in U.S.	12 V		0781	pacify Vac or No.		JSA Race - Americar	Indian
ter de	P.	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No	13. 1	Vas Decedent of His f Yes, specify Cubar	, Mexican, Puert	Rican, etc.)		Black, White, et	
urs af al", or xam	β	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2区 No	Specify:		Spi	^{ecify:} Whit	e
72 hor	ted	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupat		kina	16b. Kind o	of Business/Indu	stry
thin 7 le. lan "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	`life. L	OO NOT use retired)	aring most or wor	ang	Doz	care	
ed wi	Completed	12	Te	acher	40.48-411-11	- (Fine 14' day)			
be fill ad oth even	Be	17. Father's Name (First, Middle, Last)		1		ne (First, Middle, M	naiden Sur	name)	
d Mer narke	Į.	James Thomas Arnold 19a. Informant's Name/Relationship (Type. Print)	10h Mailin	g Address (Street ar	Eleanor		City or To	we State Zin C	Pada)
d 2 st th and 7 is n traun				g Address (Sireer ar Emerson S					· ·
1 and Healt em 2		20a Method of Disposition 20b Place	e of Dispos	sition (Name of	1			on - City or Tow	
ages ent of tt: If th		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crest	netery, cren 1aun M	natory or other place lemorial Gard) lens 1/18	/2010 M	arric	nttsvill	e, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the Me-Acal Examiner must be notified at once.		21. Signature of Funeral Service Licensee		. Name and Address		1.1			re Avenue
permi Depar Impor any Ir		Lemoft	Ga	sch's Fun	eral Hor	ne, P.A.			MD 20781
A.		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	est,	1	Approximate nterval Between
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/Medical		resulting in death) a. Due to (or as a consequence)		-100013					
Examiner		Sequentially list conditions. b.							
sit sd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):						
executed n and ial-transit	xam	Cause (Disease or Injury that initiated events resulting in death) Last C	nce of):						
icate be executed physician and s the burial-transit	-	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	,						
The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur	Physician/Medica	d							
leath certific attending pl	N/A	IF FEMALE: 23c. If yes, outcome pf pregnant					23d.	. Date of delivery	,
death e atte d for	icia	in the past 12 months? 1 Ves 2 Program at time of dea		Ectopic pregnancy Other (specify)				Month D	Day Year
w requires that the de been signed by the should be detached	hys	9 ☐ Unknown 9 ☐ Unknown							
gned oe de	by P	Part II. Other significant conditions contributing to death but not resulti	ng in the ur	nderlying cause giver	n in Part I.		4.2		cause of death?
equir sen si ould	ted	RAPIE ULUAR DISASE T	18E	2 DIAG	ETE	1 □ Ye	s 2XIN	lo 3∐ Probal	bly 4 □Unknown
law las be	Completed	HOLLIUS, Hyporrausiani, 4	PORI	- PIDEO	A	24a. Was a autops	y	prior to comp	sy findings available pletion of cause of
: The	5	OSTOOMEDHEITIS			•	perforr 1□ Yes 2	ned? 2 No	death? 1 ☐ Yes 2	P□No
ician Sertifi ector	Be	25. Was case referred to medical examiner?				th (Check only on			
Physical this call direct	ျ	1 Yes 2 No Hospital: 1 Inpatient 2 EF			4 Nursing H	ome 5 Reside			
sing f	ion:	1 Natural 5 □ Pending (Month, Day Year)	8b. Time of Injury	Work'	at ? ′es 2⊡No	28d. Describe ho	w injury oc	ccurred	
death death ctor. y the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At hom	e. farm. stre		63 2 110	28f. Location (St	reet and N	umber or Rural I	Route Number
after Ofre Jin b	Certification:	4 ☐ Homicide determined building, etc. (Specify)	.,,	, , , ,		City or Towr			,
spita nours neral filled		29a. Certifier 1 Certifying Physician: To the best of my knowle							
To the Hospital or Attending Physician: The law within 24 hours after dearh. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or in	vestigation, in my op	pinion, death occu	irred at the time, d	ate and pla	ace, and due to t	he cause(s)
To the To To the To To the Comp	ĕ	29b. Signature and this of certifier		29c. License	number	2	9d. Date si	igned (Month, D	ay, Year)
12		- Mll ms		P222	59		-i Mu	enen l'	5 2010
		30. Name and address of person who completed cause of death (Item 2		•				1	,
tel.		THOMAS MASURE, 7525 GROWING STORAGE	دن را	ALTE DE	NE # 3	12 , 512	MEST.	B-27, 1	7705 Or
Sta Registi		31. Date filed (Month, Day, Year) JAN 1 9 2010 Length A. Grand A	arks	/					
MH 17 Rev 1/2		TO LOTO person por high		<u> </u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Shirley D. Miller 2010 9:40 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🛛 F Yrs. 214-30-2472 73 **Director** May 6, 1936 Washington, DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ral", or items 23a or 28a-f shov Exercioer coust be notified at 1 ☐ Yes 2 X No Directo |Maryland| Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6021 10th Place 20782 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced r than "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ins. Monce. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin L. Pumphrey Dorothy McDonald ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman J. Miller, Jr. / Husband 6021 10th Place, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/2010 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4/739 Baltimore Avenue PAY Rogers Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septicemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of) attending pl for use as t JE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Year Month 4 ☐ Pregnant at time of death 5 Other (specify) s been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Rheumatoid Arthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an icate has l page 2 s autopsy perform 2 □No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 $\square\,\,\text{Residence}$ 6 $\boxtimes\,\,\text{Other}\,\,(\textit{Specify})$ Hospice 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records. ours after death.

neral Director: Af
filled in by the fur

Baltimore, Maryland 21215-0036

within 24 hours a

To the Funeral I

completely filled

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier J. Kouatchou

29c. License number 163748

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

1/17/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Toukep Kouatchou, 201 East University Parkway, Baltimore, MD 21218

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

32. Registrar's Signature

JAN 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0545 AM 2010 JAN /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVIL MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours NIT Known IO. NAT **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Modicial Examinational boarding any Injury or other traumatic event, Ira Modicial Examinational Consults of any Injury or other traumatic event, Ira Modicial Examinational Consults of the Consults of 10d. Inside City Limits 1 Yes 2 No MD Directo MONTGOMERY GAITHERSBUR G 10e. Street and Number 10g. Citizen of What Country? 20878 NORWICH USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: ASIAN 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAKER OWN HIME Not 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be HABIBULLAH MEMON 4YESHA MEMON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 NORWICH Ct. GAITHERSBURG MD. 20878 SARFRAZ SON MEMON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Removal from State GEORGE WASHINGTON 01/15/2010 ADELPHI MD.
22. Name and Address of Facility ADEN MUSLIM FUNERAL SER 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 1242 EASY ST. WOODBRIDGE VA - 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COLL Immediate Cause (Final disease or condition resulting in death) NONSMALL LUNG CANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of) ling physician and e as the burial-trans Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 D(No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, death certificate be Division of Vital Records,

Baltimore, Maryland 21215-0036

pital or Attending Physician: iours after death.

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filled in by the fu

To the Hos within 24 hor To the Fun completely	Modion
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Sta Registr	

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUL CHATSUME ING ROCKVILLE PIKE #401, ROCKVILLE, MD20852

D42518 JANUARY 15, 2010

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 9 2010

and manner stated.

29a. Certifier

			Plea	se Type or F State of							II Copie: Iental H		_	le.		
	Physicia		1 - State Registrar 1. Decedent's Name (First, Middle Henry Math			C	ertifica	te of	Death		2. Date of D	Da	aw	Year 2010	3. Time of 2:52	Jean S
	/Medic Examin		4a. Facility Name (If not institution Prince George	-					rLocation		Onne	7	c. County o			
_	Funeral Director		5. Social Security Number 579 – 38 – 1282			rs. la <i>s</i> t birthd Yrs	ay) If Und	er 1 Year	If Under Hours		8. Date of B (Month, D	irth Day, Year	9	9. Birthp Coun	lace (State of	or Foreign
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	death with the Maryland ms 23a or 28a-f show r. must be notified at	Director	MD P 10e. Street and Number 11109 Winsfo	.G.				in Code	iarlk !0774			10g. C	itizen of W	hat Coun	1 □Yes	2 💢 No
0036	be filed within 72 hours after death with the Marylan ttal Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be rottlied at	by Funeral Director	11. Marital Status 1													
00-c12	within 72 hour lene. than "natural the Medical E	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	it's Education st grade completed) College (1-		16a. De	ecedent's Us live kind of v fe. DO NOT	ork done use retired	pation during mos	st of work	ing	16b. ł	Kind of Bus	siness/Inc	•	
and 21		Be	12 17. Father's Name (First, Middle, George Mat				Labo	rei			e (First, Middl Willi		n Surname	e)		
, mary	nd 2 sho alth and 27 Is m r traum	To	19a. Informant's Name/Relations Thomasene Lar	hip (Type. Print) nders (Nie		111	09 Wi	nsfo	ord A	er or Rui Ave .	ral Route Num Uppe	r Ma	arlb	oro	MD.	774
baitimore	Pages ment o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		tate Ri	Place of Dicemetery,	sposition (N crematory or ale P	ark	¦1	1 – 20	-2010	Riv	erda	le i		
משו	permit. Departi Importi any Inji		21. Signature of Funeral Service Licensee 4. Signature of Funeral Service Licensee 4. Signature of Funeral Service Licensee 4. Signature of Funeral Home 908 Kennedy St. N.W. Wash, D.C. 2													1
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	e. FATA	ch line. L C	eath. Do not	tc.		ng, such as			arrest,			Approximat Interval Bet Onset and I	tween
68/60,	ite be executed iysician and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. REST	PRATE	equence of):	FRILL	RE								
O. Box 68	the death certificate be execu y the attending physician and iched for use as the burial-tra	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fe ant at time o	etal death	3 ☐ Ectopio 5 ☐ Other (cy .				23d. Date Mor		-	Year
ras, r	requires that the een signed by th nould be detache	Ş	Part II. Other significant condition	ons contributing to de	ath but not re	esulting in th	ne underlying	cause giv	en in Part	I.			,		ne cause of coably 4 🗌	
II Kecords	The law ate has b page 2 sh	Completed									24a. Wa aut pei 1 □ Yes	opsy formed?	P	Vere auto rior to co eath? □Yes	psy findings mpletion of c	available cause of
VITAI	Physician: r this certific ral director,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hoopital:	anationt 2		atient 3 🗆 I	Oth	or.		th <i>(Check</i> o <i>nl)</i> ome 5 ☐ Re		€ □Othe	r /Cnooii	5.4)	
Ion of	nding Phys ath. r: After this e funeral dir	ation: To	27. Manner of Death 1 X Natural 5 Pendir 2 Accident investi	28a. Date of (Mont)	<u> </u>	28b. Tim	ne of	28c. Inju Wor	ry at		28d. Describ				у)	
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 28e. Place	of Injury - At ig, etc. <i>(Sp</i> e		, street, facto	ory, office			28f. Location City or 7	(Street a		er or Rura	al Route Nun	nber,
	he Hospii in 24 hour he Funer: pletely fill.	Medical (s)	
	with Com	Z	29b. Signature and title of certifie) 1			2	9c. Licens	e number	L		29d. D	ate signed		Day, Year)	4
	280		30. Name and address of person ARPANA MAHAL	who completed cause	e of death (II	tem 23a) (Ty	rpe, Print)	TH	700	7	Augh.	DIV	MAX	, 76 ~25	105	C.
	Sta		31. Date filed (Month, Day, Year)	INCOCHETTY 62. RO	egistrar's Sig	gnature	Hosp	IIKZ	BK.		LHEVE	ALT,	עויי	50	100	
	Registr	ar	aun 7 9 C	UIU Cond	u p	1. 190	was			_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh g900 2-2-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 **Physician** 2010 10:30a [™] January Celine McKinney /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Frederick College View Nursing Home
Social Security Number | 6. Sex | 7. A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 🖾 F Months Days Min. Yrs. Director 63 New York 113-36-6730 June 5,1946 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 X Yes 2 □ No Director Lake Monticello Virginia | Fluvanna with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22963 United States Completed by Funeral Tobacco Terrace filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Celine 2 <u>John Hasson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McKinney Tobacco Terrace, Lake Monticello, Virginia 22963 <u> Husband</u> Robert Y. McKineey/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Stauffer Crematory Inc.1/19/2010 | Frederick, Maryland. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician JAM Cemler disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform spital or Attending Physician: The hours after death.
Ineral Director: After this certificate y filled in by the funeral director, par 1 ∐ Yes 2 No 1 □ Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Description | 1 Other | 2 Other | 3 Other | 3 Other | 3 Other | 4 Other | 4 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 Other | 5 O 1 | Yes 2 | 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 126041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herman Sha MD 65 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Mad Br. Ant.

10-00364 Kathy Ann McKii	nno	Please Type o								
Nathy Ann Micki		/ STATE (1- For State Registrar	of Maryland /	Certificate		nd iviental H		2011 g. No.	0 0267	
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last	nn McKinne			· -	2. Date of Death Month January 12	h Day Year	3. Time of Death 2303 hrs	
		4a. Facility Name (if not institution, give Harford Memorial Hospital	street and number)		4b. City, Town, Havre de	or Location of Death Grace		4c. County of Death Harford		
Funeral Director		5. Social Security Number 6. Sec. 218-72-3516	7. Age	(In yrs. last birthday)		ear If Under 24Hrs ays Hours Min.		h(MM/DD/YYYY) 9. Bird Foreig Col	thplace (State or n North ^{untn} Carolina	
ож апу		Usual Residence of Decedent 10a. State 10b. County Maryland Ceci		10c. City, Town or Lo		Deposit			10d. Inside City Limits 1 Yes 2 No	
Maryland r 28a-f show	Director	Maryland Ceci 10e. Street and Number 120 Burlin Road	1		10f. Zip Code		10	g. Citizen of What Cour	ntry?	
ith with the tems 23a o	Funeral D	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent E Armed Forces?			Hispanic Origin? (Sp an, Mexican, Puerto		U.S.A. 14. Race - Ameri White, etc.	can Indian, Black,	
irs after des ural", or i	Be Completed by		If Yes, Give Year or Dates:	No 1		No specify:	work done	Specify:	White	
036 ithin 72 houne. Inc. Tedical Exa		Elementary/Secondary (0-12) Eleven Years	College (1-4 or 5-	during		fe. DO NOT use reti		Personal F	•	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica			Bridget Ba				erna Lee	Fuffman		
MD 2. Ad 2 should alth and M m 27 is m; aumatice	٩	19a. Informant's Name/Relationship (Ty David John McKinr		band) 120	Burlin F	Road, Port	Deposi	ber, City or Town, State t, Maryland	1 21904	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner, must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify		Hopewell	other place) 1 Cemete	ry 01/		20c. Location - City or Port Deposi	it,Maryland	
		21 Signature of Funeral Service Licens 23a. Part I. Enter the disease, or compli	HEEDO	n de l'atte	Name and Addre ee A. Pa Per	ess of Facility atterson & eryville,	Son Fu Marylan	neral Home, d 21903-07	P.A. 766 Approximate Interval	
Physician /Medical Examiner		failure. List only one cause on each immediate Cause (Final disease a.)		rdiovascular Dis		g, such as cardiac o	respiratory arre	or, anock, or near	Between Onset and Death	
	Jer	Sequentially list conditions, if any, leading to immediate	Oue to (or as a consec							
xecuted n and - transit	cal Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
5 5 v		UNPENDED	AMENDED	e of pregnancy	- 85			23d. Date of delivery		
Box 68760, e death certificate be exthe attending physician ed for use as the burial	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of 5 Other (Specify)							
ords, P.O. Boy w requires that the deatl s been signed by the att should be detached for	2	Part II. Other significant conditions chronic obstructive pulmor	contributing to death		e underlying cause	e given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for un	Completed						24a. Was a autops perform	sy prior to c	topsy findings available completion of cause of	
tal Reco cian: The law certificate has	Bec	25. Was case referred to medical examiner?			26.Pla	ce of Death (Check		. • NO 1 1 1 1 e	2 140	
of Viting Physic	유	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Ye	et 2 🗹 ER/Outpatie y 28b. Time (Other Nursin		Residence 6 Other	·	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Certification;	Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
he Hospital in 24 hours : he Funeral	ical Cer	4 Homicide determined 29a. Certifier (Check only one) 2 Medical Examiner:	n: To the best of my					e(s) and manner as state		
To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Lice	29c. License number		29d. Date signed (Mor		
	-	130. Name and address of person who co	ompleted cause of de	ath (Item 23a)	0.0	C.M.E. 		January 13, 2010)	
[U st	ate		Assistant Medic		111 Penn Stre	et, Baltimore, N	/ID 21201			
Regist		31. Date filed (Month, Day, Year) JAN 2 0 2010	Denne p	1. par						
OCME 2006	<i>,</i> 0 1			ORIGIN	AL		OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	- State Amended #22perFH FCHD, K	s 1/15/18	ertificate of Deat	th	Reg.	0010	02679				
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Warren K. Meehan		2. Date of Death Month	Day Year							
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locat	tion of Death	January 11	4c. County of Death	10 HM M				
	LXamin		1917 Brookdale Road			Windsor Mill			Baltimore				
794	Funeral Director		216-12-7304 1 KI M 2 🗆 F	ge (In yrs. last birthda 86 Yrs	y) If Under 1 Year If Under 24 Hrs. 8. Date of B			orth 9. Birthplace (State or Foreign Country) Mary Land					
	and show at	o	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City										
	Maryla 28a-f	Director	Maryland Baltimore	Windsor	Mil1			1 ☐ Yes 2 🔀 No					
	h the 3a or 2 be no	al Di	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?				
	ath wit	Funeral	1917 Brookdale Road 11. Marital Status 12. Was Decedent	Ever in II S 1	21244	c Origin? (Specif		Jnited Sta					
92	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Department of Health and Mertall Hygiene. Department if the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Fi	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □		 Was Decedent of Hispanion If Yes, specify Cuban, Mean □ Yes 2 x No Specify 		can, etc.)	Black, White					
ö	ours a aturali cal Ex		3 ☑ Widowed 4 ☐ Divorced		cedent's Usual Occupation	-	404	WI	nite				
21215-0036	n 72 h an "na Medic		(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	(Gi	ve kind of work done during . DO NOT use retired)	most of working	100	o. Kind of Business In	idustry				
21	f withii ygiene her th t, the		2		Electrician		В8	0 Railroa	ıd				
Maryland	ntal H red ot		17. Father's Name (First, Middle, Last)				First, Middle, Maid	en Surname)					
يّ	ould by the mark	Ľ	James Meehan 19a. Informant's Name/Relationship (Type, Print)	19b M	ailing Address (Street and No	1en Otte		or Town, State, Zip	Code)				
ž	d 2 sh alth au alth au 27 is ertrau		Margery D'Valle/ Daughter		00 Patapsco O				/ [/ /]				
Baltimore,	e 1 an of He If iten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Di	sposition (Name of rematory or other place)	Da		Location - City or T					
<u>ä</u>	t. Pag tment rtant: njury c		4 Donation 5 Other (Specify)	Druid Ri	dge Cemetery	1/18/2	2010 P	ikesville,	Maryland.				
Ba	permit Depar Impor any ir		21. Signatur Deral Service License	W	22. Name and Address of F	uneral	Homes, P.	ille Boule .A.Mt. Air	ry, MD 21771				
П			23a. Part 1. Enter the disease, or complications mat cause shock, or heart failure. List only one cause on each lin	Α	1				Approximate Interval Between				
	hysician/		Immediate Cause (Final disease or condition		Onset and Death								
	Medical Examiner		resulting in death) Due to (or as	a conservence of):	H4 Sertens	in		years.					
		iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	a consequence oi).	Dichates	bertersion abeter			1 2				
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events c		15-				years				
	icate be executed g physician and is the burial-transit		resulting in death) Last Due to (or as a consequence of):										
1760	- D W	ledic	d										
89 ×	h certii tending or use a	ian/N		2 Fetal death	death 3 Ectopic pregnancy			23d. Date of deli					
P.O. Box 68760	requires that the death certific been signed by the attending should be detached for use as	Completed by Physician/Medical	1 Yes 2 No 9 Unknown		Month	Day Year							
, P.	res that signed I	d by F	Part II. Other significant conditions contributing to death Atrial Jibullation	23e. Did tobacco use contribute to the cause of death? 1 Dues 2 No 3 Probably 4 Unknown									
ord	v requi	olete	7				24a. Was an		opsy findings available				
3ec	Physician: The law this certificate has al director, page 2 a	omo			· per			prior to completion of cause of death? 1 Yes 2 No					
<u>a</u>	cian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner? 1										
Ž	Physic this corral dire	၉											
0 0	nding Ith. : After : funer	cate	1 Natural 5 Pending (Month, Day 2 Accident Investigation	ay, Year) 200. Time	injury work? M 1 Yes 2 No In farm, street, factory, office 28f. Location			escribe how injury occurred					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	I or Atter after des Director I in by the	Certificate:	3 Suicide 6 Could not be 28e. Tace of In	jury - At home, farm, tc. (Specify)				on (Street and Number or Rural Route Number, Town, State)					
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)										
ì	To thi within To the comp.	2	29b. Signature and title of certifier	2000 of my knowledg	29c. License numb			Date signed (Month					
			DA Heman M.D		1004	15/4		01/12/2	010				
Ó	9		30. Name and address of person who completed cause of ALHOOR HEMANI, M	death (Item 23a) (Typ	e, Print) Greene St	t- Ball	mere	MD 21	201				
	Stat Registra		31. Date filed (Month, Day) (Man 15 2010 Regist	ar's Signature	Greere St.		,						

	1	For State Registrar					ertifica		lealth and N D <i>eath</i>		Reg. No.	2010	02680
		1. Decedent's Name (First, Middle, La	ast)						2. Date of Dea	ath		3. Time of Death
Physicia		Emma	Agnes	Midd	leton					January	y 17	, 2010	8: 25 A ^M
/Medic Examin		4a. Facility Name (If n		ve street and nu	mber)				Location of Death		4c. C	4c. County of Death	
		Abbey Ma	nor					La Plata					
Funeral		5. Social Security Num		Sex 1 □ M 2 □ F	7. Age (In yrs.		Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	v. Year)	Cot	nplace (State or Foreign
Director	-	213-38-07 Usual Residence of De		X		95 Yrs.			ресе	ember 12	2,191	4 Ma	ryland
yland Now	- 1		0b. County		10c. Cit	y, Town or	_ocation						10d. Inside City Limits
a-f sh	ctor	MD	Char	les		La P	lata						1 □ Yes 2 No
or 28	Director	10e. Street and Numb	er	-	<u> </u>		10f. Z	p Code			_	en of What Cou	untry?
ath wi	lal	8410 Eves	sham Pla						.0646			SA	
tems	Funeral	11. Marital Status		Armed F	edent Ever in U. orces?	S. 13	If Yes, spe	edent of H ecify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	 Race - Amer Black, White 	
s afte	by F	1 ☐ Never Married		1 ∐Yes If Yes, G Year or D	ive		1 □Yes	2 XNo	Specify:		8	Specify: W	Mhite
2 hou	ted	1:	5. Decedent's E	ducation		16a. Dec	edent's Us	ual Occup	ation		16b. Kind	d of Business/I	ndustry
hin 7%	ple	(Specify Elementary/Second		ra <i>de completed)</i> College (1-4or 5+)	(Gir	re kind of w . DO NOT (ork done o ise retired	during most of work f)	ing			
should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Exeminer must be rediffed at	Completed	,		5 +		T	eache	<u> </u>				cation	
be fille	Be	17. Father's Name (Fi		t)					18. Mother's Nam			urname)	
ould d Mer narke	၉	Thomas Murray					Cora Agnes Clements 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						in Codo)
d 2 sh th and 7 is n traun		19a. Informant's Nam					-		Circle, N				
1 an Heal tem 2	}	Fran Rock 20a. Method of Dispos		.er	20b. F		position (Na ematory or			Date		MD 211 ation - City or	
ages ent of nt: If I		X Burial 2 □ 0 4 □ Donation 5					rs Cei			2010	Wald	orf,Mar	yland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer must be rediffed at once.		21. Signature of June			M00945		22 4 Name r	ng Addre	CHOLS FUI	VERAL HO	MF P	Δ	
permi Depa Impor any ir	İ	19cm	J C.	ELLOS					lary's Av		_		546
		23a. Part 1. Enter the shock, or heart	disease, or cor failure. List only	mplications that	caused the deat	h. Do not e	enter the mo	de of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Fi		. (wodes	My 3	parts	and .					Onset and Death
/Medical Examiner		resulting in death)		Due to	(or as a conseq	uence of):	,	,	1	,		4	
Examino.	<u>.</u>	Sequentially list condificant, leading to immediate. Enter Underly	itions,	b. Due to	(or as a conseq	uence of):	20 (T-3/	www.left	er of	15.leg)-0	
uted d ansit	xaminer	Gause (Disease or in	ring		(
ires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	Exa	that initiated events resulting in death) Las	st	Due to	(or as a conseq	uence of):							
ate be nysicia ne bur	ical			d									
ertifica ing ph	Med	IF FEMALE:											
ath ce	Physician/Medical	23b. Was decedent p in the past 12 m		1 ☐ Live	itcome of pregna birth 2 Feta	ıl death	Ectopic		У		23	3d. Date of del Month	ivery Day Year
he de	ysic	1 ☐ Yes 2 🔼 1 9 ☐ Unknown	No	9 ☐ Unk	gnant at time of on nown	death	5 Other (вресіту) _—					
that t		Part II. Other signific	ant conditions	contributing to	death but not res	ulting in the	underlying	cause giv	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
uires n sigr ld be	d by	Chromo Krohnen discare, 10 Yes								Yes 2	2 No 3 Probably 4 Unknown		
w requir s been s should	Completed	Inter	state	1 10	ns h	1801	P			24a. Was		24b. Were au	topsy findings available
The la te has age 2	omp	TCA		Kin L)	1010					rmed?	death?	completion of cause of
an: Triffica	Be C	25. Was case referred	d to medical	1 221					26. Place of Dea	1 ∐Yes th (Check only o	2 No No	T La res	
nysich	일	examiner? 1 ☐ Yes 2 🙀 N	0	Hospital: 1	Inpatient 2	ER/Outpat	ient 3 🗌 [OA Oth	er: 4 Nursing H	ome 5 ☐ Resi	dence 6	Other (Spe	Living
ng Ph fter th	L:	27. Manner of Death	5 Pending		of Injury nth, Day, Year)	28b. Time Injur		28c. Injur Wor	y at k?	28d. Describe	how injury	occurred	Stairt
tendi eath. or: A the fu	catio	2 Accident	investigation				М		Yes 2 □ No				
or Ati	Certification:	3 ☐ Suicide 4 ☐ Homi <i>c</i> ide	determine	d 28e. Plac buik	e of Injury - At ho ling, etc. <i>(Speci</i> i	ome, farm, fy)	street, facto	ry, office		28f. Location (City or To		Number or Ru	ıral Route Number,
ital Irs a ral [29a. Certifier 1	Certifying	Physician: To th	Dest of my kno	owledge de	eath occurre	ed at the ti	me, date and place	and due to the	cause(s)	and manner as	s stated.
<u>ප</u> දිම≔			And an entitle L		The second strike will	ugo, ut		II	and and place				
o the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. o the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	(Check only 2 one)	Medical Exa	aminer: On the and ma	basis of examination	ation and/o	rinvestigatio	on, in my o	opinion, death occu	rred at the time,	, date and	place, and due	to the cause(s)

State Registrar 30. Name and address of person who completed

B. Larry Jenkins, M.D. P.O. Box 2665,
31. Date filed (Month, Day, Year) 2010 32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

D0033426

La Plata,MD 20646

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g900 2-8-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** JANUARY 14, 2010 DAVID NATHANIEL MATTHEWS 5:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Year) **948** 1 **X** M 2 □ F FEBRUARY 2. 217-44-9569 MARYLAND 61 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MARYLAND PRINCE GEORGES UPPER MARLBORO 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō within 72 hours after death with 20772 8337 HEATHERMORE BLVD. UNITED STATES 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. 5 Specify: BLACK 3 Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "n any Injury or other traumatic event, the Medion. Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE TRUCK DRIVER AUTO GLASS COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES ABNER MATTHEWS. SR. ALICE MAE SIMMONS MATTHEWS ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 ARAGONA BLVD., FORT WASHINGTON, MARYLAND 20744 DENISE TOYE-MATTHEWS / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEB. 02 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY JAN. 22, 2010 CHELTENHAM, MARYLAND 21 September of Funeral Service Cicensee
LADIA C. THORNTON JOHNSON MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** presured /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural To the Hospital or Autoriantin 24 hours after death.

To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4)0 40067560 JANUARY 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>EUNICE SHAKIR, M.D.</u> 6104 OLD BRANCH AVENUE, TEMPLE HILLS, MARYLAND 20748

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

120

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 11, 2010 **Physician** Odessa Bloom Myers 1:00 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll 1716 Ridge Rd. Westminster 7. Age (In yrs. last birthday) 83 vrs If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days Hours Min. May 10, 1926 Baitimore, MD 215-22-0389 1 □ M 2X F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Carroll Westminster MD 1 ☐ Yes 2 ☐ XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 U.S.A. 1716 Ridge Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes Ž No Specify 2 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Odessa Hook William Bloom 19a. Informant's Name/Relationship (Type. Print) Sharon Panuska - Daughter 19b, Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 1716 Ridge Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) CrestLawn Mem. Gardens 1/15/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State West Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitts Funeral Home & Chapel. 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enterette disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10415 **Physician** hronce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☑ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an certificate has performed 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 2|37 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State

Medical

Registrar

29a. Certifier

29b. Signature and title of certifi

e of death (Item 23a) (Type, Print) 410

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

colm Drive Suite C Westminster, MD21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DOROTHY T. MCCUTCHEON 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsum Regional SALISOUA HICIMIC If Under 1 Year If Under 5. Social Security Number 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11-7-1928 Months 1 □ M 2 💢 F NEW JERSEY 148-22-2513 Director 81 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No DELAWARE SUSSEX **MILLSBORO** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 34484 BROADWATER ROAD 19966 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify: 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CAREGIVER HOME HEALTHCARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ STEVEN BRUSH PRUZAKOWSKI ROSE PEJKA 19a. Informant's Name/Relationship (Type, Print)
MARY ANN MATYJEWICZ/ DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34484 BROADWATER RD, MILLSBORO, DE. 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State MELSONS CREMATORY 4 Donation Other (Specify) 1-19-10 FRANKFORD, DELAWARE . Si nature of Fun 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD 32013 LONG NECK RD. MILLSBORO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failury. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician A Medical Due to (or as a consequence of): Examiner 0 HF Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🗗 Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending Natural work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death.

To the Funeral Director: After this certificate has the following the

BA 1 State

Registrar DHMH 17 Rev 7/2009 only one

29b. Signature and title of certifie

Babillal Das.

31. Date filed (Month, Day, Year) JAN 19 2010

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 Milford ST,

504B

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2010

MA

02684

		1	For State Of W	Cei	rtificate of L			g. No.		
			Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day Year	3. Time of 0	Death		
	Physicia /Medic		Helen Mae Mitcl		J		21 2010		РМ	
Ĭ	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Deat		
			Caroline Nursing Home, Inc		Dento		Date of District	Caroli		- Casaina
	Funeral Director		192-12-7289 1□M 2□xF	ge (In yrs. last birthday) 91 Yrs.	Months Days	Hours Min	Date of Birth (Month, Day, Cember 14	Year) 1, 1918 Del	hplace (State or untry) .aware	Poreign
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation				10d. Inside City	y Limits
	Maryli faho	jo	Maryland Caroline	Denton					1 🗌 Yes	2€ No
	28a	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?	
	h with	0	11200 Gregg Road		21629		Un	ited State	es of An	neric
	deat deat	ner	11. Marital Status 12. Was Deceder Armed Force:	t Ever in U.S. 13.1	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit		
21215-0036	72 hours after death with the Maryland Insturat; or thems 23a or 28a-f ahow dical Examinat must be ruillfeut at	Completed by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	X ^{No}	1 ☐ Yes 2 🙀 No				aucasiar	n
5-0	be filed within 72 ho ital Hygiene. id other than "natul event, the Medical	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done	ation during most of working ()	, 1	16b. Kind of Business/	Industry .	
121	within ene. then	ш	Elementary/Secondary (0-12) College (1-40	r 5+)		" Preparati		Home/Resta	ırant	
7	filed withi Hygiene. other then		8 17. Father's Name (First, Middle, Last)	nomem	aker/roou	18. Mother's Name (ar arre	
Maryland	2 should be filed and Mental Hygid is marked other surnatic event, it) Be	William Wilkins	Faulkner		Jane	Rhodes			
2	should ind Men imarke umatic	은	WITITAII WITKIIS 19a, Informant's Name/Relationship (Type, Print)		ing Address (Street a			City or Town, State, 2	Zip Code)	
	and 2 : ealth ar n 27 is		Esther E. Merker Daugh	ter 713	Eudeavou	Drive, Win	ter Spr	rings, Floa	rida 32	708
re,	iter of H	3	20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of ematory or other place	Da Da	te 2	20c. Location - City or	Town, State	
E	Peges nent of int: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	Denton	Cemetery	1/28/2		Denton, Ma		
Baltimore,	permit. Pege Department o Importent: If any injury or once.		21. Signature of Funeral Service Licensee	2	2. Name and Addres			cal Home,		
<u>m</u>	Dep.		Randopul 1110					enton, Mar		
ı			23a. Part1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not en line.	nter the mode of dyin	g, such as cardiac or	respiratory arre	est,	Approximate Interval Bety Onset and D	ween
ì	Physician		Immediate Cause (Final disease or condition	Duev	tja				1301	5
	/Medical Examiner		resulting in death) Due to (or	is a consequence of):					1	
		10	Sequentially list conditions, b	is a consecuence of):						
	nsit	E L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć,	lificate be executed g physician and as the burial-transit	edical Examiner	that initiated events c. The sulting in death) Last Due to (or second control or se	as a consequence of):						
68760,	te be ysicia	cal	d							
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/N	23b. Was decedent pregnant	2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify) _	<u>'</u>		23d. Date of de Month		Year
P.0	that the ed by	/ Ph	Part II. Other significant conditions contributing to deat	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of d	death?
ds,	uires sign ld be	d b	Corovary Arten	Disec	250		1 □ Ye	s 2 10 3 p	robably 4 🗆	Jnknown
Records,	w requires that s been signed t should be det	Completed by					24a. Was a	n 24b. Were a	utopsy findings	available
	sician: The law certificate has b irector, page 2 s	m C					autops perform	ned? prior to death? 2 xNo 1 ☐ Ye	completion of c s 2 □ No	ause or
tal	an: T tificat tor, pi	a)	25. Was case referred to medical			26. Place of Death				
of Vital	Physician: rthis certifica ral director, r	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp.	atient 2 ER/Outpatie	ent 3 DOA Oth	ner: 4 Aursing Hom	e 5 🗌 Reside	ence 6 Other (Spe	ecify)	
0 0	Jing Ph J. After th funeral		27. Manner of Death 1. ■ Natural 5 □ Pending (Month,	njury 28b. Time (Day Year) Injury	Wor	rk?	8d. Describe ho	ow injury occurred		
Sio	Attending or death.	catio	2 Accident investigation			Yes 2 □No	0/ 11 /04	reet and Number or F	Sured Parists Alarm	- hos
Division	or Att	Certification:	determined 200. Place of	Injury - At home, farm, st etc. (Specify)	street, factory, office	21	City or Towr	n, State)	IU/A/ HOULE IVUIII	1007,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical Ce	29a. Certifier 1 Certifying Physician: To the be (Check only 2 Medical Examiner: On the basi	of examination and/or it						s)
	thin 2 the mplet	Med	one) and manner 29b. Signature and title of certifier	SIALOG.	29c. Licens	se number	2	9d. Date signed (Mon	nth, Day, Year)	
	N N N		James Sek	BS MIN	7/2	127/		1-21-11	7	
			30. Name and address of person who completed cause of	of death (Item 23a) (Type	p. Print)	11216		21 1		-
			Temes Silves	920 M	anko-	t st	Do,	HOU!	1921	629
	Sta	ate		strar's Signature	N. J					1
	Regist		JAN 25 2010 2000	A. par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 02685 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Emil Bernard Nassau 11:35PM 5, 2010 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 15111 Glade Drive #2C Birthplace (State or Foreign Country) (In yrs. last birthday) 84 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 060-20-4420 1**½** M 2 □ F Yrs. 08/15/1925 NYC, NY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exprisher rust be retified at 1 ▼Yes 2 No Silver Spring Director MD Montgomery the 10g. Citizen of What Country? 10e. Street and Number 20906 United States 15111 Glade Drive #2C Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ₩ No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Electrical Wholesale Sales Person 12 should be filed with and Mental Hygier 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Loebenstern Charles Nassau ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra once. West Chester, PA 19380 <u>Richard Nassau / Son</u> 507 Lennon Way 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 01/08/2010 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Licen-1091 Rockville Pike Rockville, MD 20852 M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non-Hodgkins Lymphona disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1∐Yes 2K∑No 1 ☐Yes 2 🗷 No 26. Place of Death (Check only one) funeral director. Be 25. Was case referred to medical Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Tyes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan 18111 Prince Philip Drive #327

D35635

Olney, MD 20832

01/15/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Nathan Ronald Neal 2010 02686 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January 8, 2010 0255 hrs Medical Examiner Nathan Ronald 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Foreign Months Days Hours Director 1 XX 2 F 22 Aug. 19, 1987 Wash 579-13-6920 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 X Yes 2 No 28a-f shov Washington DC I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10e. Street and Number 10g. Citizen of What Country? United States 20020 2303 Minnesota Ave., Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Yes 2 X No è 3 Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: Black ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ic event, the Medical 21215-0036 Bolling Airforce Housekeeper 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kebe El Carmella Neal Nathan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2303 Minnesota Ave.
Washington DC 2005
20b Place of Disposition (Name of cemetery)
20 Date Carmella Neal/mother nt: If item 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1/15/10 1 X Burial 2 Cremation 3 Removal from State Pages 1 **P**ark Landover, Md. Harmony Memorial 4 Donation 5 Other Specify. 22. Name and Address of Facility Hodges & 3910 Silver Hill Rd., nature of Funeral Service Licen Edwards F.H. Suitland, Md. 20746 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Medical Death a. Sharp Force Injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔲 DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject was stabbed Natural FOUND: 1 Yes 2 V No Pending Director: 24 hours after death Jan 8, 2010 0215 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 1608 Brightseat Road , Landover, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 8, 2010 OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Earl Lee Newby 2:00 January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Month, Day 1 n . 20 Min. Year 949 1 X M 2 1 217-50-3356 Jan. 60 Director Indiana Usual Residence of Decedent or 28a-f shov 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Marvland Cecil Elkton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 18 Tree Lane 21921 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: 3 ☐ Widowed 4 🂢 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Chrysler Corporation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Sander Newark, Delaware Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Marie McClure Archie Wilmer Newby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Old Field Acres Drive, Elkton, MD Angela Shrewsbury (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Harford Memorial Gardens 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/21/10 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Si priure of Funeral Service Livensee ²Lee Ad Adress of Ferry 2001 & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anc disease or condition Medical resulting in death) Due to (a a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy eral **Director:** After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ᅆ Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

State Registrar

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2:55P M NIMMO ELEANOR F. 20 2010 Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Vantage House Howard 9. Birthplace (State or Foreign Country)
Ireland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ■ M 2 🔀 F 94 153-03-5643 Director Mar.7, 1915 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at Howard 1 ☐ Yes 2 No Director MD notifled Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or þe 6718 White Gate Road 21029 must United States Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Medical Examiner 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 0, ryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 Federal Paper College (1-4or 5+) Department of Health and Mental Hygien Important: If Item 27 is marked other tha any injury or other traumatic event, the Jonee. the Bookkeeper Chemcial Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nina Baastad George F. Goltenboth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6718 White Gate Road, Clarksville, MD Ruth E. Nimmo/Daughter 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Cemetery 4 □ Donation 5 □ Other (Specify) 1/24/2010 | Federalsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final te **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and as the burial-trai CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) 68760 ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 50 Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. δ þe Dementia, Renal Insufficiency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 (No 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 X Yes -2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending investigation Division 1 Natural 2 Accident 1 Yes 2 No 11/12/2009 9:35 p. M Subject slipped and fell. 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5400 Vantage Point Road, Columbia, MD 4 Homicide ō Assisted Living Facility 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leath Al comman 31. Date filed (Month, Day, Year) Registrar's Signature State Registra

DHMH 17 Rev 1/2001

			1 - State of Maryland / Del	partment of Health and ertificate of Death		ne _{No.} 2010	02689			
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Edith K. O'Brien		2. Date of Death	Day Year	3. Time of Death			
	Examir		4a. Facility Name (If not institution, give street and number) Fairhaven	4b. City, Town, or Location of Death Sykesville	h	4c. County of Death Carroll				
ł	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 2 1 2 - 20 - 8112 7. Age (In yrs. last birthda 87 Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) 5/18/1922	ear) 9. Birthplace (State or Foreign Country) Maryland				
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Md Carroll Sykesvi			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	ath with the 23a or 28	Funeral Director	10e. Street and Number 7200 3RD Ave	10f. Zip Code 21784		Citizen of What Coun	try?			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hurry or other traumatic event, if a l'adical Exemination until to multiful anonce.	by Fune	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give If Yes, Give Year or Dates;	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, e	etc.			
Baltimore, Maryland 21215-0036	ithin 72 hounder.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of wor . DO NOT use retired)	king	Sb. Kind of Business/Industry				
and 21	i be filed w intal Hygier ed other th	Be	2Yrs. Hous 17. Father's Name (First, Middle, Last) Walter H. Kincannon	ewife 18. Mother's Nan Edith Ma	ne (First, Middle, Maio	omemaker den Surname)				
Mary	id 2 should Ith and Mei 27 is marke traumatic	욘	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Ru 3RD Ave. Sykesvil	ıral Route Number, Cit		Code)			
more,	Pages 1 a nent of Her ant: If item ury or othe		20a. Method of Disposition 20b. Place of Discemetery of		Date 20c.	Location - City or To				
Balt	permit. Departi Importi any inj) 1 2 ()	21. Signature of Fundial Service Licensee	22. Name and Address of Facility aight Funeral Home .O. Box 195 Sykesv	e & Chapel ille,Md. 2	P.A. 21784.				
	hysician /Medical	3 1	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death			
	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):	0						
Ď,	ficate be executed physician and s the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last C							
7 68/6U	certificate to ding physics as the b	/Medical	IF FEMALE:							
.O. Box	e law requires that the death certificate by the attending has been signed by the attending in 2 should be detached for use as	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)	***	23d. Date of delive Month	ry Day Year			
coras, r	I ne iaw requires that the ate has been signed by thoage 2 should be detache	2	Part II. Other significant conditions contributing to death but not resulting in the		d tobacco use contribute to the cause of death? ☐ Yes 2 No 3 Probably 4 Unknown					
H Reco	cate has be	Completed			24a. Was an autopsy autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No					
<u> [a</u>	rnysician; r this certifica ral director, p	Be	25. Was case referred to medical examiner? Hospital:		ath (Check only one)					
5	or this	5	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of Death		ome 5 Residence)			
ISION .	Attending death. sctor; Afte by the fune	Certification:	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident Investigation	Work? M 1 □Yes 2 □No	28d. Describe how in 28f. Location (Street		Pouto Number			
<u>.</u>			29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	City or Town, Sta	ite)	otod			
į	in 24 i	Medical	one) and manner stated.	nvestigation, in my opinion, death occur	rred at the time, date a	and place, and due to	the cause(s)			
	WIL O	2	29b. Signature and title of centifier	29c. License number D34849		Date signed (Month, D				
	12			D34849 berty Rd E	· Kersbu	3 MD à	21784			
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hade						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 15, 2010 Joseph Pietrangeli, Sr. 6:30 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11019 Oakwood Street Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Y Nov. 18, Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 390-12-2926 1 🖾 M 2 🗆 F Year) 1919 90 Yrs Wisconsin Director Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at Director Silver Spring Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 20901 USA 11019 Oakwood Street Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married 1 ¥ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 WWII 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical Engineer Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosalia Dimario Frederick Pietrangeli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5020 Lake Circle Court, Columbia, MD 21044 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Fred E. Pietrangeli/Son Jan. 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Ins Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 2090 Signature of Funeral Service Licenses 0 and 23a. Part 1. Enter t1. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Stroke mins. Medical resulting in death) Due to (or as a consequence of): Examiner Longstanding Hypertension yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎦 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 N this certificate 2 🗌 No Be (25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work Accident
Suicide s after death. 1 Yes 2 🗌 No the Investigation To the Hospital or Atter
within 24 hours after dee
To the Funeral Director
completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the hasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6+1 D19170 Jan. 18, 2010 rique! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1400 Forest Glen Road, Silver Spring, MD 20910 Alan I. Kermaier, MD 31. Date filed (Month, Day, Year) State JAN 19 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 15, 2010 **Physician** 8:40A. LORE PERL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth Mar. 15, 1913 Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Austria 214-70-0036 1 □ M 2 🛛 F 96 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show should be filed within 72 hours after death with the Marylar and Mental Hyglene.
marked other than "natural", or items 23a or 28a-f shov marked other than "natural", or items 25a or 28a-f show marke event, "in "A. Can E-aminer must be notified at marke event," in "A. Can E-aminer must be notified at 1 ☐ Yes 2 📉 No Maryland Prince George's Beltsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3901 Harrison Road 20705 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: White Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education atth and Mental Hv. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked c any injury or other traumatic eve once. Franz Rollig Anna Steiner ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Solomon Perl - son 16916 Vine Court Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns 1/18/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be execute attending physician and for use as the burial-trans Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) been signed by the a should be detached f ☐Yes 2 No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dementia; Breast Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 2 🗓 No 2 X No 1 □ Yes is after deau.

ral Director: After this ceru... 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.0. Division of Vital Records,

3altimore, Maryland 21215-0036

or Attending filled in by

10

To the Hospital or within 24 hours at To the Funeral D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29a. Certifier

29b. Signature and title of certifier

and manner stated.

29c. License number D22966

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2010

Thomas H. Burguieres, M.D. LRH 7300 Van Dusen Road Laurel, Maryland 20707

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 19 2010



SR. 4b. City, Town, or Location of Death 12, 2010

4:10 \mathbf{P} M

10d. Inside City Limits

1 X Yes 2 No

4a. Facility Name (If not institution, give street and number) 6805 DULUTH STREET 5. Social Security Number

LANDOVER

4c. County of Death

PRINCE GEORGE

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" --- any injury or other traumatic event." Directo Funeral Completed by Be

ဥ

7. Age (In yrs. last birthday) Days Months

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours 8-1-1929

JANUARY

 Birthplace (State or Foreign Country) CLEVELAND, OH

579-36-4265 Usual Residence of Decedent 10a. State 10b. County

MD PRINCE GEORGE

LANDOVER

10c. City, Town or Location

10g. Citizen of What Country?

10e. Street and Number

10f. Zip Code 20785

U.S.A.

6805 DULUTH STREET

11. Marital Status 1 Never Married 2 Married 3 ☐ Widowed 4 🔀 Divorced

80

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No

14. Race - American Indian, Black, White, etc. BLACK

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Specify:

Elementary/Secondary (0-12) 12th

College (1-4or 5+)

COMMISSIONER

GOVERNMENT

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname) ETHEL DARBY

CLARENCE PRIDGEON

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

GARY PRIDGEON SR./SON

20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State

56 GREEN KNOLL BLVD HANOVER, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place)

4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FT. LINCOLN CEMETERY 01-21-2010

BRENTWOOD, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

7474 LANDOVER RD LANDOVER, MD 20785

Physician /Medical Examiner

burial-tran

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attending properties for use as as

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director

in by

After

after death Director: the

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Physician/Medical

Be Completed by

Certification: To

Medical

physician

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Immediate Cause (Final disease or condition resulting in death)

CARDIORESPIRATORY FAILURE

Due to (or as a consequence of)

HYPERCHOLESTEROLEMIA Due to (or as a consequence of)

DIABETES MELLITUS TYPE II

Due to (or as a consequence of)

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1X Yes 2 No 27. Manner of Death

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be

determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work?

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

JANUARY 13, 2010

29a. Certifier

I 🛣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

29b. Signature and attle of certifier

MD# 32274

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

UNMI KO KIM, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422

State Registrar

31. Date filed (Month, Day, Year) JAN 1 9 2010 82. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

autops, performed? Vas 24 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, 28e, 28f and Peral Me g901 3 19 10 TT
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Gladys Wooster Parcover 14, 2010 5:51 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fort Washington Hospital Fort Washington Prince George Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🛣 F Months Days Hours 213-26-0362 March 17, 1915 Connecticut Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State 1 ☐ Yes 2 📉 No Bryans Road Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3196 Fraser Road 20616 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Post Master U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry L. Wooster Dasiy Parsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Kline Son 3085 Wooster Dr., Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 18, 2010 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 21. Signature of Funeral Service Licer 22 Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Complications from left femur fracture Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducito (or se a eonecouchec of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

and

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signed by the a

has page

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician: The law requires that the death certificate be executed

or Attending

Hospital

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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Be Completed

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Experieur mast be retified at

the Medical

Director

Funeral

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ould be fil Mental F

Health tem 27 i

permit. Pages
Department of
Important: If it
any Injury or o

IF FEMALE:

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 1 □ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1☐ res 2☐ No 27. Manner of Death

5 Pending

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 1/4/2004 investigation

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

yard

28c. Injury at Work? 28b. Time of MAG 1 ☐ Yes 2 No

28d. Describe how injury occurred tell

Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify)

[row 28f. Location (Street and Number or Tural Route Number, City or Town State) Rd Bryans Rd, MI Bryans Rd, MD 3196

1/14/10

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day

1 | Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

lathe mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arvind Narasimhan M.D. 11711 Livingston Rd., Fort Washington, Md. 20744 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,	he Hospital or Attending Physician: The law requires that the death certificate be executed

	1 - State Registrar Co	ertificate of Death	Reg. No. 2010 02691					
Physician	1. Decedent's Name (First, Middle, Last) Leonard B. Parks, Jr.	2. Date Mor Janu						
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
LXAIIIIIEI	Long View Nursing Home	Manchester	Carroll					
Funeral Director	5. Social Security Number 216–24–9491 6. Sex 1 X M 2 F 81 7. Age (In yrs. last birthda		e of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) 1/1/1928 MD.					
land ow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation	10d. Inside City Limits					
Mary F sho	Maryland Baltimore Upperco		1 ∐Yes 2 💥 No					
or 28a	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
23a c	4100 Black Rock Road	21155	United States					
Description of a should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If iten 27 Is marked other than "natural", or items 23a or 28a-f show amy highly or other traumatic event, In Moulcel Examination and December once. To Be Completed by Funeral Director	1 Never Married 2 Married 1 X Yes 2 No 1954 If Yes, Give 1954	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 No Specify:	s or No- late.) 14. Race - American Indian, Black, White, etc. Specify: White					
natur Jicol	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of working	16b. Kind of Business/Industry					
ed within 72 hou ygiene. The than "naturale than "	Elementary/Secondary (0-12) College (1-4or 5+) Busi	ness Owner	Refuse Removal					
y rail of the file Mental Hy arked oth atic event	17. Father's Name (First, Middle, Last) Leonard B. Parks, Sr.	18. Mother's Name (First, Francis Eli						
and 2 sho eaith and n 27 Is m	Joseph C. Parks - son 1791	ling Address (Street and Number or Rural Route 7 Marshall Mill Road	Hampstead, Maryland 2107					
Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra	4 Donation 5 Other (Specify)	1						
permit. Depart Depart Import any inj once.		22. Name and Address of Facility Eline F						
4 202 80	23a. Part 1. Enter the disease, or complications that caused the death. Do not e	334 S. Main Street, Han	7					
Physician /Medical	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Difficile col	atory arrest, Approximate Interval Between Onset and Death					
Examiner	Sequentially list conditions b. I substitute	2 Hilos						
sit sit	if any, leading to immediate cause. Enter Underlying							
rificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):							
re be siciar e buril	d.							
rtificate be ng physici as the bu	IS SERVALE.							
Attending Physician: The law requires that the death cert redeath. The factor. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use affication: To Be Completed by Physician/M		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year					
es that igned by be deta	Part II. Other significant conditions contributing to death but not resulting in the	e. Did tobacco use contribute to the cause of death?						
w requires been sign should be	Atrial Fibrillation		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown					
: The law requirecate has been sugge 2 should		248	a. Was an 24b. Were autopsy findings available prior-to completion of cause of					
cate har page	<u> </u>	10	performed? death?]Yes 2 No 1 □ Yes 2 No					
ysician: The his certificate I director, page	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check						
Phys or this oral dir	27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA Nursing Home 5	☐ Residence 6 ☐ Other (Specify) scribe how injury occurred					
nding ath. r: After e funer	Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	, ,					
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	Suicide Suicide Homicide Suicide Su							
o the Hospit thin 24 hour the Funer ompletely fill	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due investigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)					
Vith vith com	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
IL. IL.	· Rawallo 1110	D51705	1-11-2010					
MY MO		som DR, Mast	minter malto.					
State Registrar	31. Date filed (Month, Day, Year) JAN 1 2 2010 32/Registrar's Signature	and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gertrude Louise Phillips 9, January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore** GBMC Hospital Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 ▼ F 70 Director 213-38-7306 4/18/1939 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedfeal Examinations by notified at 1 ☐ Yes 2 X No Directo Baltimore Monkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21111 USA 16905 York Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 □Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No <u>م</u> Specify. 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Mary Hare John Edward Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18918 Calder Ave., Parkton, Md. 21120 Louis Phillips, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2010 Hampstead, Md. Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 S. Main Street, Hampstead, Md. 21074 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinitelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 poinths?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 st autopsy performed certificate 1 □ Yes 2 💢 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after death.

It Director: After this of in by the funeral d this 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a Funeral L 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32

Registrar's Signature

YORK R.D. MONKTO

Baltimore, Maryland 21215-0036

Box 68760,
P.O.
/ital Records,
Vital
Division of

		_ For		State of	of Mary	land / Dep	artment of H	Health and	d Mental Hy	giene		
	-	State Registrar				Ce	rtificate of	rtificate of Death			2010	02696
		1. Decedent's Name	e (First, Middle	e, Last)				2			Year	3. Time of Death
Physicia /Medic			is R. P				Januar	у 18,	2010	11:05 a ^M		
Examine		4a. Facility Name (li	f not institution	n, give street and ne	umber)		4b. City, Town, o	or Location of De	eath	4c. C	ounty of Deat	h
		301 Sun	shine	Way			12.11	minster			Carro	
Funeral		5. Social Security N	umber	6. Sex 1 □ ★M 2 □ F		yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. (Month, D	rth <i>ay, Year)</i>	Co	hplace (State or Foreign untry)
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and		10a. State	10b. County		100	c. City, Town or Lo	ocation				-	10d. Inside City Limits
Maryl -f sho	ģ	MD	Com	roll		Most	minster					1 ∑ Yes 2□No
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ms 2	Funeral	11. Marital Status	SUIISIIII	12. Was Dec		in U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No	0- 14	. Race - Ame	
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72 hc natu	Completed	(Spec	15. Deceden	t's Education st grade completed	()	(Give	edent's Usual Occup kind of work done	during most of	working		of Business/	,
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examers and be multihed at once.	}	4 Donation			(Carroll 2	Cremation	n Inc	1/22/10	Hamps	stead,	Maryland
permi Depar Impor any ir		21. Signature of tu	ineral Service	Licenses			.2. Ivallie and Addit	P:	ritts Fun	eral	Home &	Chapel PA
		23a Part 1 Enter 1	he disease or	complications that	caused the		112 Washi	_			ter, M	D 21157 Approximate
		shock, or hea	art failure. List	only one cause on	each line.	1 11	\	ing, coon ac can	dide of respiratory	arroot,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	òn	a	ma	11 cell	hung	<u> </u>				5/27/09-1/18/10
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uted d ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	erlying injury	S								
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w requires that the de been signed by the should be detached	Phys	9 🗆 Unknown		9 0 0 0	KIIOWII			1			-	
ss the	by F	Part II. Other signif	ficant conditi	ons contributing to	death but no	ot resulting in the	underlying cause gi	ven in Part I.				the cause of death?
equire en si ould b	ed								_ 1_	Yes 2□	No 3	robably 4 Dunknown
e law re has be	Completed								24a. Was	s an		utopsy findings available completion of cause of
The ate h	E O								per 1 □ Yes	ormed?	death?	2 🗆 No
ician: The certificate rector, pag	Be (25. Was case refer examiner?	red to medica	1					Death (Check only	one)		
hysic his ce I dire	일	1 Yes 2 □	Mo	Hospital: 1	Inpatient	2 ER/Outpatie	ent 3 □ DOA Ot	her: 4 Nursir	ng Home 5 🖸 Res	sidence 6	☐ Other (Spe	cify)
Attending Physician: The law requires that the death certificate in death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	:uo	27. Manner of Deat	th 5 ☐ Pendir		e of Injury onth, Day, Ye	ar) 28b. Time (of 28c. Inju	ıry at rk?	28d. Describe	how injury	occurred	
eath. or: A	cati	2 Accident	investi 6 ☐ Could	gation				Yes 2 No				
or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determ	inad 26e, Plac	ce of Injury - Iding, etc. (S	At home, farm, s Specify)	treet, factory, office			(Street and wn, State)	Number or R	urai Route Number,
urs al		00-0-17	15 200				Al Al A					
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the		amination and/or i						
thin (Mec	29b. Signature and	I title of certifie		anner stateu.		29c. Licen	se number		29d. Date	signed (Mont	th, Day, Year)
F Š F 8		▶ N n	2	P. mad	2 1 1/2					1/1	9/11)
Mar	j	36.)Name and add	LUT 1	who completed as	Use of death	(Item 23a) (Type	Print)	ソレナ		111	111	/
10		Maril	TICP	SSES .	th ("	ter Sit	Tex lin	Hour Star	115 d.M.	57		
Sta	te	31. Date filed (Mon	,		Registrar's	Signature		1. 1100.0	1, ,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 12:38 A.M Felice Ouinto January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth
(Month, Day, Year)
April 11,1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1X M 2 □ F Country)
Italy Director 577-68-4932 80 Usual Residence of Decedent 23a or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10404 Kardwright Court 20886 Italy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Photo Journalist Associated Press injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vito Paolo Quinto Caterina Zinninni Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Quinto/Wife 10404 Kardwright Court, Montgomery Village, MD.20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important; If ite any injury or otl 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 1/18/2010 | Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home tes 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Pneumonia months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or imjury that initiated events and that the death certificate be exect Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 the use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown φ Month Day Year Pregnant at time of death Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, Coronary Artery Disease 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Kidney Disease performed? 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe

State

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

D0058542

10605 Concord Street, Kensington, Maryland 20895

January 17, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George Roldan 625 PM L. 2010 OI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Puerto Rico 078-36-0697 62 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 14128 Grand Pre Road, #14 20851 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Ø Yes 2 No 1968 – If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. b 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Puerto Rican 3 X Widowed 4 Divorced Completed White 1970 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Ches 12 Restaurant other Be permit. Page 1 and 2 should be filed.
Department of Health and Mental HoImportant: If item 27 is maany injury or other. Maryland 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Julia Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, Maryland 20851 Jessica Roldan - Daughter 1221 Highwood Road. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 [X] Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place) 01/22/2010 Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Severe COPD Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Seizure Disorder Due to (or as a consequence of) resulting in death) Last Physician/Medical Cardiac Arrest IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lung Cancer 1 Yes 2 No 3 Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of Left Pneumonectomy 24a. Was an autopsy After this certificate har funeral director, page performed? death? 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Handlent 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the ba 3 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 45 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sima Nourani Zenuz, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Rollins Elizabeth Lucretia 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Frostburg Frostburg Village Nursing Home Date of Birth (Month, Day, Oct 5, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 1□ M 2□ ₹ 212-24-0806 82 Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Exertmine" in set by neither at MD Allegany Cumberland 1 □¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21502 400 Piedmont Avenue USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ Xio \$ Specify. 3 □ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Doctor's office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Lininger Olive Patton Lininger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Timothy Rollins** 122 Wilmont Avenue MD 21502 Cumberland son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State St. Peter's Cemetery 1/12/2010 MD Westernport 4 □ Donation 5 □ Other (Specify) 21. Sign thre of Fundral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic 24ems Carolovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) the detached 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Vasialar disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a Was an has certificate 2 No 1 □Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a, Certifier (Check only one) Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 worsock Shi D0055325 MD Jan 07, 2010 \circ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar WONSOUK SHIN
31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Walsh Rd Cumberland MD21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Francis Ricker, Sr. 13. 2010 10:35 /Medical James January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friendsville Rest Area Friendsville Garrett If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 1 M 2 □ F Yrs. 80 03/28/1929 Director 213-24-7479 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner nust be polified at 1 ☐ Yes 21 No Director MD Allegany LaVale 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 21502 USA 916 Dolly Terrace Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23: 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married 1946-1 □ Yes 2 ☑ No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced 1947 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Meat_Packaging 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Ricker Alice McAllister ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Joretta L. Ricker / Wife 916 Dolly Terrace, LaVale, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 01/14/2010 | Cumberland, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. First. Em. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 1 No 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Area 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054004 January 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Shiv C. Khanna,

JAN 14 2010

31. Date filed (Month, Day, Year)

M.D.,

32. Registrar's Signature

1221 National Highway, LaVale, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vear W Richardson Phyllis 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Devlin Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD Social Security Number Date of Birth (Month, Day, You Jun 18, 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □X Months Days 217-18-4129 Director 87 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination to exciting at Allegany MD Cresaptown 1 □Xes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 13120 Warrior Drive USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify If Yes, Give Year or Dates: ģ 3 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Office Sacred Heart Hosp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar T. Whitlock Ruth Martin Whitlock ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21001 1011 Stepney Road Aberdeen Martha Grace daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Hillcrest Memorial Park 1/12/2010 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 dag Greens /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy In the past 12 months? Day Month Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2-1 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊒Hó 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 1 Hu

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ATROllin

31. Date filed (Month, Day, Year)

JAN 13 2010

D0017565

12,2010

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G901, 374/2010, WS
State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Owar Month Year d PM Medical 10:00 January 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Baynew Medical Center Baltimore Sex 1 M 2 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 211-18-4333 Director 83 Country) Feb. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7709 Wynbrook Rd 21224 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give ģ 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced WWII Specify: Year or Dates White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaging. Highway Safety Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Control Assistant Lamplighter's Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Spencer Lee Ruby Elma Charity (Bennett) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Exec. 7709 Wynbrook Rd., Baltimore, MD Thomas A. Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/01/2010 20c. Location - City or Town, State Mt. Zion Christian Cem Jan 30 10 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chaneysville, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Hafer Funeral Service, P.A. so ch 1302 National Hwy., LaVale, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Physician/ Respiratory failure Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner effusion pleural Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury tachycoundia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Director: After this certificate yes 2 No death? 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗷 No 1 Yes ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-00 January 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8+1 Eboni Lance 707 North Breadway Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 0605 Leonard William KiKer 13,2010 anvary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Brooke Grove Assisted Living-The Meadows Sandy Montgomery Spring If Under 1 Year / If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Dec. 10 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Davs Hours 89 295-05-8220 Dec. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show try or other traumatic event, fre. In-clical Experimental Les Auffind at ury or other traumatic event, fre. In-clical Experimental Les Auffind at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Md. Sandy Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20860 United States 17715 Dominion Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 White WWII 1 ☐Yes 2 📉 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9 Driver/Delivery Food n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann Dabinett Riker Mary Leonard W. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. 24109 Woodfield School Rd., Laytonsville, Md. 20882 Cindy Baruch / P.O.A. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/18/10 Mt. Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses Zo Box 5038, Laytonsville, Md. P. O. 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 8 \(\text{Other} \) (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after deatn. al Director: After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier t Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2046

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

gave Brookettuffman, M.D. 18100 Stade School Road Sandy Spring

mo, attending physician

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:39 AM 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MARTIAND DEDICA UNIVERVITA Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under **Funeral** Age (In yrs. last birthday) Y^{ear)}1<u>945</u> Months Aug. 17 Country)
Pennsylvania Days Hours Min. 219-42-2163 1 □ M 2 🔀 F 64 Yrs. Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Carroll County Hampstead 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Houcksville Road Funeral 21074 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) sales clerk retail sales 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Rill Melvin Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4601 Lynncrest Drive Hampstead, Maryland 21074 19a. Informant's Name/Relationship (Type, Print) Ethel M. Myers - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Carroll Cremation 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 🗌 Burial 2 💢 Cremation 3 🗆 Removal from State 1/18/2010 Hampstead, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) MEMUTATIC CARCINONO Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine cause. (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes I XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, 113 HOUPITHUU ho

NJL

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:30 Stiefel JAN 10 2010 а /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Springhouse at Westwood Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Months Days Hours Min. 1 □ M 2 🕅 F Yrs. MAR 21, 1916 UNKNOWN 93 116-10-4673 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 TYes 2 No Director MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5101 Ridgefield Road 20816 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: Specify: Caucasian ò 3 X Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Aviation Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Mendel Sherman Rebecca Gladstein ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert M. McCarthy / Guardian 4405 East West Hwy, Bethesda, MD 20814 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 01/12/2010 Ridgewood, New York Mt. Judah Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of FacilityThibadeau Mortuary Service, p.a.7 Park Avenue, Gaithersburg, MD 20877 21. Signature of Funeral Service Licer Mu M00956 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Lendie CEVabroVAKULAN DISGASE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner The law requires that the death certificate be executed

Funeral

Director

show

r than "natural", or items 23a or 28a-f sho

with the Maryland

filed within 72 hours after death

Il Hygiene.

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, the longe.

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

of Vital

Division

Hospital or Attending Physician:

death. neral Director: F

after

To the Hospital within 24 hours a To the Funeral C

Examiner and physician ar s the burial-t Physician/Medical as 1 attending properties for use as the detached à signed b ₫ should Completed cate has t page 2 s After this certificate I funeral director, page Be Certification: To

autopsy performed? 1 Yes 2 No

1 ∐Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

25. Was case referred to medical

31. Date filed (Month, Day, Year)

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature

14

29c. License number H45839

1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) January 11, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1119 Rockville Pike, #316, Rockville, MD 20850 Gary E. Raffel, D.O.,

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 8, 2010 **Physician** Jeanne Sundheim Spiegel 1010 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | North | Days | Hours | Min. | 10/23/1926 9. Birthplace (State or Foreign Country) PA 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🖫 F 86-24-3915 83 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Expredient in ust be retified at MD Silver Spring Montgomery 1 Kes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 11621 New Hampshire Avenue 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify ₹ A Yes Give 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrater Engineering s 1 and 2 should be filed w if Health and Mental Hygier Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev Stanley Rosskam Sundheim Julia Bacharach Nusbaum ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter D. Spiegel - son <u>5225 Pooks Hill Road #A29S Bethesda MD 20814</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State National Crematory 1/15/2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) M01163 22 Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Perforated Duodenal Ulcer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of): Box 68760, certificate be Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes Mellitus, Hypertension, Chronic Kidney Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.0. Division of Vital Records, spital or Attending Prours after death.
neral Director: After / filled in by the funers Hospital 24 hours a

To the I within 2 To the I 20

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JAN 14 2010

Medical

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

Rajan Shyamsundar MD 9801 Georgia Avenue #117 Silver Spring MD 20902

and manner stated

3. Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D53367

29c. License number

29d. Date signed (Month, Day, Year)

January 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10, 2010 Elizabeth Sipe 6:30 Mary January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Layhill Center Silver Spring Montgomery If Under 1 Year | If Under 24 H Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Sex **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 1917 Pennsylvania Director 168-28-7026 92 July 19, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Directo Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4218 Isbell Street 20906 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 🕱 No Specify Specify: þ 3 k Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Nursing Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injuy or other traumatic event once. 17. Father's Name (First, Middle, Last) Be ည Cummings Delia Rogers John Leo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4218 Isbell Street, Silver Spring, Maryland 20906 Maura L. Olson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2010 Gate of Heaven Cem. | Silver Spring, MD. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Drive, Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Atrial Fibrillation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the 9 I Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 24a. Was an autopsy performe certificate | 2 □ No Division of Vital 1 □ Yes 2**7** No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1∐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 🕅 Natural 5 | Pending Within 24 hours arren www. 7 To the Funeral Director: Af 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier tt Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) January 11, 2010 D 64208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Pre Road, Silver Spring, Maryland 20906 Saadia Husail, M.D., 3227 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:00PM Elizabeth 05 2010 01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Cumberlance County 5. Social Security Number Home nursing If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Months 1 □ M 2 🖫 F 73 5-29-1936 220-32-2604 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medital Examiner must be notified at gonee. 1 MYes 2 No Director MO Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 21502 USA Oldtown 1514 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home maker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GAUMER MERIDITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd Apt A Comberland MD 21502 Shatter Robert 1514 oldtown Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 1-7-2010 Buffalo Mills MADLEY CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 169 Clarence St Mony HYNDMAN PA 15545 Zeigler Harvey H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2HEIMER'S Physician END STAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, learning to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the attending physician and the derivation of the bound of the print o Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier sunerh

500 memorral Ave suite 201 Comberland MO 21502 OR Robustiano Barrera 31. Date filed (Month, Day, Year) JAN 21 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician

/Medical

Examiner

Funeral

Director

29b. Signature and title of certifier

Directo

Completed by Funeral

Be

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For State Registrar			Cer	tificate	e of L	Death			Reg. No	21	10	1 12710
. Decedent's Name (First, Middle, La	ist)							2. Date of De	eath	<u> </u>	1	3. Time of Death
Frances	Delor	es	S	haff	er			Month Janua	ry 1	_	Year 010	1620 M
a. Facility Name (If not institution, giv				4b. City,		Location of			40	. County		
Western MD Regior						berla				A		gany
Social Security Number 6. S	Sex 7.Ao 1.∐M.2√2.F	ge (In yrs. last b 84	oirthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bit (Month, Di 04/24/	rth <i>ay, Year</i> 1025)	C	rthplace <i>(State or Foreign</i> o <i>untry)</i> ryland
216-22-5036 sual Residence of Decedent		04						04/24/	1925		ria	ryland
Da. State 10b. County		10c. City, Tov	_									10d. Inside City Limits
MD Alle	gany		Cum	berla	and							1 ☐ Yes 2 🌠 No
De. Street and Number				10f. Zip		4500			10g. C	itizen of W		ountry?
13509 Sentine	l Lane, Ni	9			2	1502				US	A A	
. Marital Status	12. Was Decedent Armed Forces)	13. W	as Deced Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	0-		e - Ame k, Whit	erican Indian, te, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No	1	□Yes 2	2 ∏ No	Specify:				Specify	' :	771
15. Decedent's E	Year or Dates:	16	a. Decede	ent's Usua	al Occup	ation			16b. J	Kind of Bu	White Business/Industry	
(Specify only highest gra	ade completed)		(Give k	ind of wor O NOT us	rk done d	uring most	of work	ing		01 00	.5666	
Elementary/Secondary (0-12)	College (1-4or 2	0+)	S	ecret	tary				Dev	elop	men	t Commission
7. Father's Name (First, Middle, Last			~					e (First, Middle			e)	Ŧ ,
James	Edward		Smit	n 		E1	1а 		Beni	ta 		Jackson
9a. Informant's Name/Relationship (E. Diane Shaffer								al Route Numb NE, Api				<i>Zip Code)</i> burg, VA201'
a. Method of Disposition		20b. Place	of Dispos	ition (Nan	ne of ther plac	e) ;		Date	20c. L	ocation -	City or	r Town, State
1 Donation 5 ☐ Other (Specif				•			1/21	/2010	Cu	mber.	lan	d, MD
1. Signalure of Funeral Service Liee	nsee	L	22.	Name an	d Addres	s of Facilit	y Ac	ams Far	nily	Fun	era:	1 Home, P.A.
MAMON DIC	idans		41	04 De	ecati	ır St	reet	, Cumbe	erla	nd, l	MD	21502
(1)				. 0								
3a. Part 1. Enter the disease, or com	nplications that cause one cause on each I	d the death. Do ine.	not ente	r the mod	e of dyin	g, such as	cardiac	or respiratory a	arrest,			Approximate Interval Between
shock, or heart failure. List only mmediate Cause (Final	one cause on each I	ne.		r the mod	le of dyin	g, such as	cardiac	or respiratory a	arrest,			Interval Between Onset and Death
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Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical Examiner

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vikramaditva Poonai, M.D., 924 Seton Drive, Cumberland, MD 31. Date filed (Month, Day, Year) JAN 19 2010

32. Registrar's Signature

29c. License number

D36766

29d. Date signed (Month, Day, Year)

21502

January 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#2perPHYS, G900, 2/16/2010, WS State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2. Date of Death 01 January 2010 ear 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 8:50a **Smiley** Robert L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Bethesda** Montgomery Suburban Hospital Birthplace (State or Foreign Country)
 Alabama 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1**X** M 2 □ F 80 416-32-2565 **Director** June Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryianu ment of Health and Mental Hygiene. In the Maryianu fant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Completed by Funeral Director DC N/A Washington 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1444 Primrose Road, N.W. 20012 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 1951
If Yes, Give 1053 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No **Black** Specify: Specify: 1953 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Research Entomologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ James Smiley Cherry Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa K. Smiley/Daughter 1444 Primrose Road, N.W. Washington, DC 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of h Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State Zion Memorial Gardens 01/09/2010 Birmingham, AL 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. Signature of Funeral Service Licensee 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTRUCTIVE PULMOWARY

DISEASE Immediate Cause (Final Ph_sician/ HRONIC disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Lus to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day certificate has been signed by the injector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KNo မ 1 Propatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Katural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Em, MD 00057124 1/13/10 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truang Bao, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) JAN 19 2010 Registrar's Signatur State acked

Registrar

			For State Registrar	State of N	Maryland		artment o			lental H	ygiene	2010	02711
			1. Decedent's Name (First, Midd	lle, Last)						2. Date of D	eath		3. Time of Death
я	Physic /Medi		Nathan Silve	man						Month Januar	cy 13	, 2010	2:00P ^M
May .	Exami		4a. Facility Name (If not institution	on, give street and numbe	er)		4b. City, Tow	vn, or Location	on of Death			ounty of Death	
un'			6111 Montrose	Road Apt. 6	27		Rockvi				Moi	ntgomer	У
	Funeral		5. Social Security Number	6. Sex 7. A 1X M 2 F	Age (In yrs. la		If Under 1 Y Months D	ear If Und	der 24 Hrs. rs Min.	8. Date of B (Month, D	irth Day, Yea <i>r)</i>	9. Birthp Cour	place (State or Foreign htry)
	Director		132-07-9059	VAL IVI ZUI	91	Yrs.				July 3	31, 19	18 New	York
	and and		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
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	death	ner	11. Marital Status	12. Was Deceder	nt Ever in U.S	3. 13.			Origin? (Sp	ecify Yes or N Rican, etc.)		Race - Americ	
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003	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorce	Year or Dates	s:		10163 20	ino spec	y.		5	pecify: W	hite
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d 2	Hygid Hygid ther	ပို	12 17. Father's Name (First, Middle	Last)			Owner_	18 Mc	other's Name	e (First, Middle		Restaur	ant
Maryland 21215-0036	d be ental	To Be	Jacob Silvern	•					nie Va		o, maraon ba		
JZ.	shoul nd M mar	F	19a. Informant's Name/Relation			19b. Mailir	ng Address (St				ber, City or T	own, State, Zip	Code)
	alth a 27 is 27 is r trai	L	Michelle Gind	loff/Daughte	r	9813	Glynsh	nire W	ay Pot	tomac,	Mary1a	and 208.	54
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at the notified at once.		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name o	of r place)	1	Date	20c. Loca	tion - City or To	own, State
Ē	Page nent ant: If		1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (3		e i		ebanon	<i>p</i>	1/15	/2010	Glend	iale, N	ew York
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	90 F % 9		Wellsigh	GHERMUT "10	1397		1091 Rc	ckvil	le Pil	ke Rock	ville	, MD 20	852
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Division	al or Attendi s after death. al Director: A ed in by the fu	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 28e. Place of II	njury - At honetc. (Specify)	ne, farm, str	eet, factory, off	fice		28f. Location	(Street and f	Number or Rura	al Route Number,
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Angela Santisi Concetta Ser Jan. 13, 2010 **Physician** Angela 12:22а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Hyattsville 6404 Riggs Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/13/1924 Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F 86 Italy 579-58-6266 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experiment must be a cultified at 1 ☐Yes 2X No Hyattsville Director Prince George' MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6404 Riggs Road Italy 20783 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White ģ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. 7 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmelo Santisi Carmela Santisi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 Is i Tindara Bilmanis/Daughter 7321 Sara Street New Carrollton, Md 20784 Itimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Ft.Lincoln Cem. 1/16/2010 Brentwood, Md
PHTL TPACES RENALDI FUNERAL SERVICE, P.A. 4□Donation 5 NOther (Specify) Entombment 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months Congestive heart failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Et a Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed and use as the burial-tran Due to (or as a consequence of) Box 68760, physician pe Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for In the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö detached 9 Unknown signed by t σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ hypertension, diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐Yes 2 ☐ No of Vital 1 ☐ Yes 2 🗷 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home St Residence 6 Other (Specify) 1 Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined or A 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

To the Hospital of within 24 hours at To the Funeral D

29a, Certifier

29b. Signature

30. Name and address

31. Dave filed (Month, Day,

Medical

and manner stated.

of person who complete cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

John Merendino M.D.

Year)

9

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D36046

10215 Fernwood Road Bethesda Md

29d. Date signed (Month, Day, Year)

Jan. 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ .^{Day} 010 3:50a 18 Eugenia Sarduy Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Days Months Hours Min. 3 /26 / 7 9 9 6 091-42-4934 Cuba 93 Director Usual Residence of Decedent shov 10c. City, Town or Location or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Montgomery Bethesda 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 9 "natural", or items 23a or Funeral 4521 East-West Highway #1501 20814 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 ¹ ☑ Yes ² □ No Specify: Cuban 3 X Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress/Tailoring Clothing 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည traumatic Francisco Ortiz Maria Lorenzo Foster 1 and 2 should b f Health and Mei ttem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose R.Santiago/Son 4309 Knowles Avenue Kensington, Md 20895 other Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of Important: If it any injury or o once. cemetery, crematory or other placel 1 Burial 2 X Cremation 3 Femoval from State Chesapeake Crem. 1/19/2010 Beltsville, Md. 4 Donation 5 Other (Spec 21. Signatural Fund al Service I i PHTLITPddB: TTWALDI Funeral service, p.a. 9241 Columbia Blvd.Silver Spring, Md 2091 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Coronary artery Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Live Birth 2 Fetal death ō in the past 12 months? Month Day Year Pregnant at time of death 2 🔀 No Yes the g þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? has page 2 this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify OSPICE 1 🗌 Yes 2 😾 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending work' 1 Tes 2 No M 24 hours after death Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my entities at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 D33755 Jan. 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Bindu

Joseph M.D

2. Registrar's Signature

6000 Muncaster Mill Rd Rockville, Md 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 9, 12 per fh g901 3-9-10 vt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dominick Saltaformaggio, 4:20a M Jr. 2010 Januaru 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3692 Thornbury Court White Plains Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 27, 1938 9. Birthplace (State or Foreign Code Quisiana **Funeral** 1**X** M 2□ F Months Days Hours Min. Director 434-52-4185 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov raumatic event, Its Medical Examination must be in differed. Director 1 X Yes 2 □ No Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3692 Thornbury Court Funeral 20695 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1955-1X Yes 2 No 19
If Yes, Give
Year or Dates: Navy 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 1959 Specify: 3 Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Optical Lab Technician Optical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Mamie Cardionella Dominick Saltaformaggio. Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Taylor - Daughter 22512 Treadaway Street, Mandeville, LA 70471 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Comment Lake Lawn Park Maus. 01/20/2010 New Orleans, Louisiana 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee Hines-Rinald

25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏕 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? the Hospital or Attending Physician; The law cate has t autopsy performed? Yes Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only or 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending within 24 hours after death.

To the Funeral Director: A Sympletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) O

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN

19

32 Registrar's Signature

The law requires that the death certificate be executed Box 68760. P.O. Records, of Vital

Division

Maryland 21215-0036

Saltimore,

cate has been signed by the page 2 should be detached tal or Attending Physician: These after death.

al Director: After this certificate ed in by the funeral director, pa filled in by To the Hospital o within 24 hours af To the Funeral Di

Be

Medical Certification: To

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 ☐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 🗆 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0063196

Jan.15,2010

ess of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Matthew Andrew M.D. 115 Rhode Island Ave. N.W Washington, D.C.

State Registrar 31. Date filed (Month, Day, Year) JAN 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOAN M. SMITH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND WESTERN MD REGIONAL MEDICAL Social Security Number 178-32-1021 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours 87264 1938 Copring) Director Usual Residence of Decedent if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗖 No SOMERSET MEYERSDALE, PA10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15552 usa Funeral 4473 BRUSHCREEK ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces þ 1 Never Married 2 Married Yes 2 XNo WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) SEWING FACTORY WORKER permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ttt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEORA A FELKER WILLIAM HENRY DEIST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
138 WEST FURNACE STREET WELLERSBURG, PA 15564 CAROL SARVER / FRIEND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 1/15/2010MT LEBONAN CEM GLENCOE, PA 21. Signature of Funeral Service Licenses M² NAY CECKEMBY FUNERAL HOME 203 NORTH ST Ray 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner VPERTEN Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHOCKSTEREL EMITA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No 2 No Yes 25, Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work Natural 1 Tes Accident
Suicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) WY) JAN 11, 2010 12057 /0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

nos

Gregg Donaldson, M.D.,

31. Date filed (Month, Day, Year) **JAN 1 4 2010**

Registrar's Signatur

912 Seton Drive, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 5 per fh e902 4-2-10 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** 9:50 AM EIEANOR Mae Shelley 01 07 2010 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminister Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Jun 18, 1930 Birthplece (State or Foreign Country)
 MD 5. S**2115**626 46846 216-22-7491 6. Sex **Funeral** 1□ M 2□ FX Days Hours Min. 79 Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b Counts f Health and Mental Hyglene. Item 27 is marked other then "natural", or iteme 23a or 28e-f show other traumatic event, the Medical Examene must be notified at **Prince Georges** MD Lanham 1 ☐ Yes 2 ☐ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6523 Midra Drive 20706 USA r death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 | Yes 2 | No 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be David Elmer Grapes Evelyn Mae McCrea Grapes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6523 Midra Drive Lanham MD 20706 19a. Informant's Name/Relationship (Type, Print)
Robert Shelley husband Pages 1 and 2 ment of Health a 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Davis Memorial Cemetery 1/11/2010 Cumberland permit. Page Department of Importent: If any injury or once. injury or MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funey Service Licensee 22. Name Scarpelli Fulleral Home, PA 23a. Pert. Inter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death CHROMYOPATHY **Physician** /Medical **Examiner** Sequentially list oundrions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Á After this certificate has been signed the funeral director, page 2 should be determined. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 4 Donknown 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. injury at Work? 28d. Describe how injury occurred 27. Manno of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Natural 5 Pending 1 🗌 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Dey, Year) d title of certifier 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

11 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2010 9:57 a M Tasker Strong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 3/5/1924 Jacksonville.Fl Director 85 262-28-9330 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Suitland 1 ₹ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 3843 St. Barnabas Rd. #204 United States be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 In and Mental Hygiene.
7 Is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) 8th Retired Military Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Strong Laura Dunn other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant; If item 27 is Barnabas Rd. V. Strong/Wife St. #204 Suitland, Md. <u>Delores</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 1/26/2010 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Eacility Pope, P.A. 5538 Mariboro Pike/ Forestville, Md. 20747 ~101055 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a. ATHEROSULERUTIC Immediate Cause (Final Physician CARDIOVASCULAR DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MU12MATSA 9 PH Sequentially list conditions, Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician; The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No by the g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PROSTATE CANCER METASTATIC 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy nerforn certificate 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? To the Hospital or Attending Physic: within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral director. Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ÆR/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) K Ma Legon MD.

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL (C. MAAAAM)

22. Registrar's Signature

CENTER

JAN 1 9 2010

31. Date filed (Month, Day, Year)

7503 SURLATTES ROAD

150689

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20735-

SULTHERN MARYLAN

To the within 2 State Complete Complete Registrate

29b Signature and title of certifie

Pamela E. Southall, MD

9

32. Registrar's gignature

Assistant Medical Examiner

and manner stated

of person who completed cause of death (Item 23a)

butherell, mi

ORIGINAL

00ME

29d. Date signed (Month, Day, Year)

January 13, 2010

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 06:00 a^M 2010 alnia /Medical 4b. City, T 4c. County of Death 4a. Facility Nator (If not institution, give street and number) **Examiner** Prince Residence 10006 Edgewater Terr. Washington Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Social Security Number **Funeral** Min. Months Days 1 □ M 2 💢 F Hours 225-10-3/69 Director 1924 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1¥ Yes 2 □ No Director Ma. 10g. Citizen of What Country 10e. Street and Number 5 20744 5 or items 23a 10006 Jater Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify. Š Black 3 ₩Widowed 4 □ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Its Magnes." Elementary/Secondary (0-12) College (1-4or 5+) omemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bealle Maggie ortune Oliver ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 320751 Alexandria Na 22320 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Alexandria, Va. 20 2010 Cemeter Name and Address of Fa 2. Name and Ad Wingia ure of Funeral Sec 5801 207 37 23a. Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final METASTATIC LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 🖾 No Ö 9 Unknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ HYPERTENSION; ANEMIA; DVT 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown plnods Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 🗆 No ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 01,000 01/18/2010 VA 0102-035626 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRAHOS, С. D.O. MICHAEL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 2010

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Loraine Simpson January I^{ay}, 2010 6:00 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5704 Norman Ct. District Heights Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Ye 1 🗆 M 2 🖾 F Days 1932 Gretna, Va. Director 77 152-26-3547 28a-f show 10a. State 10h County illed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Prince Georges 1 X Yes 2 □ No Forestville 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 5704 Norman Ct 20747 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or \$ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Statistician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Coles Belle White Rosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Simpson / Spouse 5704 Norman Ct. Forestville, Md. Joseph 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 1/21/2010 Cheltenham, Md. 22. Name and Address of Facility Pope. P.A. 5538 Mariboro Pike/ Forestville, Md. 21. Signature of Funeral Service Licenses 23a. Part. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Coronary disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner s a consequence of): that the death certificate be executed burial-transit Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? page certificate I 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?
1 ♣ Yes 2 □ No **Division of Vital** funeral director, Be B 26. Place of Death (Check only one) Hospital Other: |2 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Accident

2 Accident

3 Suicide

4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one d title of certifier 29b. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 10612unc

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOL

HD 33106

1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** JANUARY 4 2010 6:30 a M FRANCES Μ. SUTTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Nursing & Kent Rehab Chestertown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 13 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Davs Hours 1 □ M 2√2 F 1912 Maryland Yrs Sept Director 217-36-2219 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exprimer must be notified at 1 □Yes 2 No Director MD Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 21645 U.S.A. 12061 Locust Grove Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ∏Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail Sales 12 injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Ella Thawley Hope C. Copper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Helen Stephens (daughter) 602 Woodland Ave. Lot 19 Ruskin, FL. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/8/2010 Galena Cemetery Galena, MD. 21. Signature of Eurieral Service 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St.Galena, MD. 21635 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** UV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physician a the burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) signed by the a I be detached f 9 Unknown 9 Unknown Part I**I. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy O 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case refer examiner? d to medical 26. Place of Death (Check only one) Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 No 2 Accident investigation 1 Tyes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m 1ami 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. Benjamin, M.D. 6602 Church Hill Rd. Chestertown, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JANUARY ROBERT WILLIAM 9:46 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. I 1 і 🛣 м 2 🗆 F Months Days Hours Min Year)925 Mary Tand **Director** 214-28-7221 84 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Frederick Frederick è 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 72 hours after death with 21702 United States 5321 Old National Pike 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) State Government Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edith Cecil Earl Stup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old National Pike, Frederick, MD 21702 <u> Lorraine Stup / Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mount Olivet 1/14/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician the burial burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year the detached Unknown 9 Unknown s been signed by should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' certificate 1 Yes No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 Tes Other: မ this 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manus of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending a after death.

I Director: Af in by the fu 1 \square Yes ☐ Accident 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) MDD16428 death (Item 23a) (Type, Print) 30. Name and address of person who completed caus a 300 W. 9th Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) r's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 2010 LARUE BELL SMITH 9 45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18, 1922 Funeral 9. Birthplace (State or Foreign 217-12-1868 1 □ M 2√3√F Months Hours Director 87 Yrs. Mary Land Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City. Town or Location the Maryland Director 10d. Inside City Limits 28a-f Frederick Walkersville Maryland 1XXYes 2 II No 10e. Street and Number 10f. Zip Code 21793 ms 23a or must be r ò 10g. Citizen of What Country? Funeral 43 E. George Street USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o Department of Health and Menta Important if item 27 is marked any injury or other traumations. မှ Leroy Myers Laura Geiman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Smith - husband 21793 43 E. George Street, Walkersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State Resthaven Memorial 1-16-2010 Frederick, Maryland 4 Donation 5 Other (Specify) Sig a ure of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ischemic Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) 1 | Yes 2 No 9 | Unknown Pregnant at time of death Month the detached Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown Renal 24b. Were autopsy findings available prior to completion of cause of death? Chronic 24a. Was an agemia Jas autopsy page perform certificate Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital ၉ 1 Tes Other: 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 340h ttiren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 32. Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 2 7 2

Certificate of Death Reg. No. 3. Time of Death

1. Decedent's Name (First, Middle, Last) **Physician** 4:45A M Schettini January 22, 2010 Jennie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Caroline 23168 Deer Run Court Denton 8. Date of Birth (Month, Day, Year)
Feb. 25, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Director 91 1918 Massachusetts 034-03-7489 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examinar must be retified at 1 ☐ Yes 2 No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 U.S.A. Funeral 23168 Deer Run Court 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify ≥ Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked: any Injury or other traumatic evance. Sabatino Caimbrelli ည Michelina Lamberti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21629 <u>Joseph A. Schettini</u> 8283 Laurel Lane, Denton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Jan.22,2010 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA W. Sunset Ave., Greensboro, 21639 Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Box 68760 Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregrant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) P.O. 9 Unknown ģ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform rmed2 2 ∐No After this certificate of Vital 2 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred t edical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2010 30. Name and address of peron who completed cause of death (Item 23a) (Type, Print) 508 21601 Robert Sanchez, MD Idlewild Ave., Easton, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

JAN 25 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygien & U | U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Louise Stewart 7:45p^M 1-8-2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George Bradford Oaks Nursing Home Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year)
11-5-1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2**X** F Hours Yrs. Director 90 578-30-0153 WashingtonDC Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be modified at Director 1 Yes 2 □ No Upper Marlboro MarylandPrince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9160 Darcy Rd 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No þ 3 ☐Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Scrivner Estelle Crowdy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any Injury or other traurr once. <u>9160 Darcy</u> Rd,Upper Marlboro MD 20774 <u>Lois Holland</u>/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1-15-2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 21. Signature Funeral Service Licensee 22. Name and Address of Facility M01589 Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or) Physiclan: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 000 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Yes 2 No Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Name and

31. Date filed (Month, Day, Year)

Box 68760,

P.O.

of Vital Records,

Division

dress of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar		State	OI IVIS	aryiand		ndelible Inl 15/2010 That timent of E tificate of E		ia M		giene Reg. No	001	0	02728
Physicia	n/	1. Decedent's Name (First, Middle, Last)									Date of Death Month Day Year			ar	3. Time of Death
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Funeral Director		5. Social Security No. 221-12-12-12-12-12-12-12-12-12-12-12-12-	6. Sex 1 ☐ M 2 🏻 F				If Under 1 Year Months Days	If Under 24 Hours	Hrs Min,	8. Date of Bir (Month, Da 3/29/1	y, Year)	9.	Birthp Count	lace (State or Foreign ry) MD	
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD 10e. Street and Nun	Kent			Chestertown 10f. Zip Code						10 - 0	itizen of What	0	1 🗆 Yes 2 🛣 No
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items ner mu		11. Marital Status		12. Was De		ver in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin	? (Spec	cify Yes or No-		14. Race - A Black, W	merica	
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To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r			e Birth 2	2 🗌 Fetal o	death 3	Ectopic pregnanc	ey .				23d. Date of		•
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the ful		2 Accident 3 Suicide	ation	M 1 🗆 Yes 2 🗆 No					006						
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		30. Name and address	D	ho completed car	use of de	eath (Item 2		rint)							
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Registra	ir		JANZ	U ZUIU	A CONTRACTOR	and the	19	V # J W							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** John Joseph Schuh, Jr. 2010 /Medical Rehabilitation Ctr. Winfield 4a Facility Name (If not institution, give street and number)
Brinton Woods Nursing & 4c County of Peath Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 13KJ M 2 □ F Hours 148-07-5815 Director Aug. 18, 1917 Deans, NJ Usual Residence of Decedent filed within 72 hours after death with the Marylend 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at Carroll Winfield MD 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 U.S.A. 1442 Buckhorn Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 월 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Colonial Tank Transport Truck Driver s 1 a. of Health end... If Nem 27 is marked ou... 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health end Mental Mary Ryan John J. Schuh, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6839 Autumn View Dr., Eldersburg, MD 21784 19a. Informant's Name/Relationship (Type, Print) Daughter Linda Gregg -20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) = 0 1 Burial 2 ☐ Cremation 3 N Removal from State Department of Important: If any injury or Resurrection Cemetery 1/11/10 Piscataway, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Pritts Funeral Home & Chapel, P.A 21. Signature of Funeral Service Licenses 412 Washington Rd., Westminster, MD 21157 P-II1. Entar the Isease, or cook cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed buriai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the Due to (or as a consequence of) attending p for use es sate hes been signed by the a page 2 should be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Tyes 2 d No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s efter death. ii Director: Aff ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed-(Month, Day, Year) 29b. Signature and title of certifier WJL 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #7, per F. Home, 1/19/2010, Certificate of Death E.T., WCHD Reg. No. Amended item 1. Decedent's Name (First, Middle, Last) 01/16/2010 **Physician** 8:05 A M Ronol A. Strickland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Atlantic General Hospital Salisbury If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign NC Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 223-14-6894 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Its Modical Expinition must be notified at 1 ☐ Yes 2 ☑ No Ocean City MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21842 12804 Old Bridge Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 1XXYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2/☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Edwards Henry Clay Strickland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28980 Mt. Vernon Rd. Princess Anne, MD 21853 Department of Health Important: If item 27 any Injury or other tra Donna Koga (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/18/2010 Frankford, DE |Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): 5. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Stricklend Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? /スダ // デュゥ ひゃ Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 200 1 ☐ Yes 2 🗷 No 1 ☐Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 pinpatient 2 □ ER/Outpatient 3 □ DOA Certification: To ð 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division o 1 Natural
2 Accident 5 ☐ Pending investigation ours after death.
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filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Symula 10 9733 Healthmay Drive 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atlantic General Hospita E. 1 5+1 Szymala no 31. Date filed (Month State Registrar

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State 31. Date filed (Month. Day, Year) 32. Begistrar's Signature			_	31. Date filed (Mor			rar's Signature	S	arke							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Month Lester D. Shockley, Jr. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBUM Centu HICOMIC If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** MD Country) 1 K M 2 🗆 F Days Hours Min 11^{(M}005, Ply9^{Y22}9 80 Director 221-18-1699 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1- Yes 2 No Snow Hill Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21863 USA 7316 Whiton Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Yes 2 K No Yes, Give þ 1 Never Married 2x Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify.White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Lester D. Shockley, Sr. Maude Godfrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7316 Whiton Rd., Snow Hill MD 21863 Rosine Pollitt Shockley (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Zion Cemetery 01/20/2010 Snow Hill MD 4 Donation 22. Name and Address of Facility The Burbage Funeral Home neral Service Licensee 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition chemi Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No cate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate 1 Yes 2 No Yes 2 Physician: Division of Vital completed filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 읻 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director, After 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifle Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signatu 29c. License number

44 AM

Year

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-Bergmuelle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month Day **Physician** Patricia Ann Schissler 13, 2010 3:13 a January /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Months 1 □ M 2 K F 68 Director 212-40-5882 Dec 4, 1941 Maryland Usual Residence of Decedent i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "---" 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Experience rust to retified at 1 XYes 2 ☐ No Director Maryland Carroll Taneytown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 35 Hayride Lane 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivah Fowler James Sturgill ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Hayride Lane, Taneytown, MD 21787 Donald R. Schissler, husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grd 101/16/2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): ocknows Disese Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and burial-trar Due to (ir as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ♠No 3 Ectopic pregnancy tate has been signed by the atte page 2 should be detached for i Day 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 1 ∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and man stated. To the I within 2 To the I 29b. Signature and title of certified NJL completed cause of death (Item 23a) (Type, Print) 30. Name and address of person, 10 WESTMINST 31. Date filed (Month, Day) Year, 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 19a per F.D. 01/19/2010 Carroll County, will State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:05PM ILTINA 9LADYS STEM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Aug 7, 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1925 Days Months Hours Min 1 □ M 2 🗷 F 84 Yrs 196-14-7140 Director Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Manchester 1 ☐Yes 2 No Maryland Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Medical Eventinat De no once. 21102 2708 Mt. Ventus Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant/Bar Owner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Concetti Maiorino Michael Lostaglia ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3295 Bullfrog Road, Taneytown, MD 21787 1971 Croria Man Terariv Cepe. Daughter Vicki LeFaivre, daughter 20b. Place of Disposition (Name of Screen, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 1/19/2010 Carroll Crematory Winfield, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee -136 E Baltimore St, Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, alrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonecuence off Examiner Hospital or Attending Physician: The law requires that the death certificate be exeluted as the burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part, II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Myrican dial 2 No 3 Probably 4 Unknown 1 🗍 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy Severe 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manuar of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier ۲ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) Medi within 2. and manner stated. To the 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) WJL 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIN ST. WESTMINGTER MID 21157 447. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/03/2010 **Physician** 3 4 M KEN THOMAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13117 Twinbrook Parkway. #201 Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 1**X** M 2□ F 42 249-31-9106 Director 06/11/1967 SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 13117 Twinbrook Parkway, #201 20851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian Black White etc. 72 hours after 1 X Yes 2 □ No 1988— If Yes, Give Year or Dates: 1989 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 21X No ģ Specify. 3 Widowed 4 Divorced 1989 Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If I.M. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Housing 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Colvin Thomas Thelma Metoyer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandon P. Roberts - son 164 Pond Oak Lane, Irmo, SC 29212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Palmetto Cemetery 1/12/10 Columbia, SC 22. Name and Address of Facility Snowden Funeral Home 21. Signature f uneral Service Lice 246 N. Washington St, Rockville, MD 20850 Part1. Enter the diseas shock, or heart failure e, or complications that caused the death List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final Physician 100170 disease or condition resulting in death) /Medical Due to (or w a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending p IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) P.O. the signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1/1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an las l autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1/ Natural 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p

> State Registrar

(Check only

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

14

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moms

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 550 PM 10 Charles Edward Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Golden Living Center Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 21, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F Yrs 1923 Director 215-12-2050 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County or 28a-f show tem 27 is marked other than "natural" or Items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Cumberland 1 √Yes 2 No MD Allegany Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 314 Reservoir Avenue Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cumb.Post Office Superintendent is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie V. (Manuel) Thomas Charles W. Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is □ MD 21502 Cumberland wife 314 Reservoir Avenue **Betty Thomas** permit. Pages 1 and Department of Healt Important: If item 2: any injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2010 Restlawn Memorial Gardens MD LaVale 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Furgeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 3 Probably 4 Unknown 2 No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No INSUPPICIENCY 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

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State of Maryland / Department of Health and Mental Hygiene 2

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State Registrar 30. Name and add

(Month, Day, Year) JAN 1 4 2010 IENUE CLUMBERIANDIMID 2502

N. Veisram

ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 1:50 am Vui Thi Ta January 15. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Vietnam 8. Date of Birth (Month, Day, Year) 01/02/1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F Director 586-26-6960 77 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examiner roust be notified at 1 ☐ Yes 2 X No Director Greenbelt Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8011 Craddock Road 20770 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🕱 No þ Specify: 3 Widowed 4 Divorced Asian "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Sen Thi Lam ဂ္ Thuong Ta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duke La - Son 8011 Craddock Road, Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Pk. 01/20/2010 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early in e. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 No
9 □ Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 □ Yes 2 🕻 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To

Box 68760, P.0. Division of Vital Records. After

filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed ieral Director: A within 24 hours after To the Funeral Dire

State Registrar 31. Date filed (Month, Day, 19 2010

5 Pending investigation

6 □Could not be

determined

27. Manner of Deat 1 A Natural 2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signature

30. Name and ad

4 Homicide

9

completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 🗆 Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 No

005757 Y

28f. Location (Street and Number or Rural Route Number, City or Town, State)

() cv wood

28b Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT WILLIAM THOM 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center **Allegany** Cumberland If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 86 Director 219-14-5036 11/28/1923 Maryland Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD Cumberland Allegany 10g. Citizen of What Country? 10e. Street and Number 1719 Bedford Street 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2M Married 1 ☐Yes 2XNo Specify: Specify: WWII þ WHITE 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 1) Celsnese Fibers Corp Elementary/Secondary (0-12) College (1-4or 5+) is marked other than 2) State of Maryland Lab Worker 2) Inspector 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Thom Helen Dennison ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Joan B. Thom / Wife 1719 Bedford Street, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ©Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify.) Hays Mt.Zion Ch. Cem. 11/14/2010 Berlin, PA 22. Name and Address of Facility
Upchurch Funeral Home, 21. Signatuje,of Funeral Service Lice 202 Greene Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cian COLONau 20 Gears disease or condition resulting in death) dical Due to (or as a consequence of): iner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 □Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29b. Signature ind title of certifier 12,2010 9+ Name and address of person who completed cause of death (Item 23a) (Type, Print) -924 Jeton (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year TETHERO エノ 01 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) 69 yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 228-52-8407 1 🛣 M 2 🗆 F Days Hours Min. 1 0 / 1 9 / 1 9 4 0 NC Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Brentwood MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4219 Cottage Terrace 20722 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Rlack. White, etc. δ 1 Never Married 2 Married ☐ Yes 2 🎛 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Laborer 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hughey Tillman Viola Bowman 19a. Informant's Name/Relationship (Type, Print)
Dorothy M Redfear 19b. Mailing Address (Street and Number or Rural Route Number City or Taya, State, Zip Code) 1111 Lindsey RD, Oxon Hill MD 20745 - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cometery, crematory or other place)
Riverdale Park Cre 1/22/2010 Riverdale, MD 22. Name and Address of FacilityDL McLaughlin Funeral Home 2019 MLK Jr Ave SE, Wash. DC 20020 21. Signature of Funeral Service Licensee 3a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Ceretoro Vascu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence on physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performe 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu/ and title of certifier 29c, License number luzasachi (las, MD D0063703

State

31. Date filed (Month, Day, Year)
JAN 2 0 2010

22.-Register's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABTAS ACH WAR

Registrar

TAKOMA PARK,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			A District	partment of Health and N Prtificate of Death		ne no.2010	02740				
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death				
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-	Examir		4a. Facility Name (If not institution, give street and number)	4c. County of Deat							
			Prince Georges Hospital	Cheverly		Prince Georges					
ı	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birti 1918	hplace (State or Foreign untry) SC				
	pud *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits				
	laryla stro	ō		Location			1 ☐ Yes 2X No				
	28a-	Director	MD Prince Goerges Largo 10e. Street and Number	10f. Zip Code	100	Citizen of What Co					
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	ms 2	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,				
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marical Evant har must be notified at	ρ	Armed Forces? 1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	ack				
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	permit. Page Department of Important: If any Injury or once.			on National 1-22		uitland,	MD.				
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	or the rospital or Attending Prystician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	4 Homicide determined determined determined building, etc. (Specify) 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 287. Location (Street and Number or Rural Route Number, City or Town, State)								
	e nospi 24 hou e Funer letely fill	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the best of my k	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)				
	Withir Comp	Me	29b. Signature and title of certifier	29c License number	29d. [Date signed (Month	, Day, Year)				
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	2	-	30. Name and address of person who completed cause of death (Item 23a) (Type	. Print)	0	NUARY 11 Y, MD 2	, - 0.0				
1	-)		ARPANA MAHALINGASHETY, MD 30	OI HOSPITAL DR	(HEVERL	4, MD 2	0185				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:33 A.M Manth 17/2810 **Physician** Talbert Ellen Sam /Medical 4c. County of Deeth 4b, City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMER Grouse Gaithersburg Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day. | -30 -9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) **Funeral** 08345420 Williamport, PA 1 ☐ M 2 💢 F Yrs Director Usuef Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Marylan tent of Health and Mental Hygiens.
ant: if item 27 is marked other then "natural", or items 23a or 28a-f ahow ury or other teamstic a vant, it is Marked to it in the Marylan in the most be notified at ury or other teamstic a vant, it is Marylan Examina must be notified at 1 XYes 2 No MONTGOMER Jaithers Burg Director 10g. Citizen of What Country? 10f. Zip Code SA 20879 STOUSE Lane Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) re kind of work done during most of working DO NOT use retired) Colfege (1-4or 5+) Elementary/Secondary (0-12) IEACHER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GERTRUGE Walton ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4TH ST. NW., WaSH. [Bianca N. Platter/daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Beltsville, MD. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Wash.DC. ZOOOZ HENTY Funeral Home emu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA fmmediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, as the attending for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death signed by the aid be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown COPA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en performed? 1 ☐ Yes 2 ☑ No 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ZYes 2 □ No 10 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier JANUARY 20,2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 ROCKVILL PIKE C.Hablani, MD, PC ROCKVINE, maryland 32. Registras Signature 31. Date filed (Month, Day, Year) State JAN 2 0 2010 Registrar

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Barry G. Troupe 3:15a^M Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 248 Willard Drive North East Ceci1 8. Date of Birth
(Month, Day, Year)
Jan. 6, 1943 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 🖳 M 2 🗆 F 190-32-2585 67 PA **Director** Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No MD Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 248 Willard Drive 21901 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. I hours after death v Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event the Machine II. 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1962-63 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Customer Representative Construction Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ၉ Charles H. Troupe Elizabeth Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Megretha C. Troupe/ wife Willard Drive North East, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/21/2010 me, P.A. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation R.T. Foard Funeral Home, Rising Sun, MD Sign and of Ineral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. MD 2191i Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. by signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown icate has been siç ; page 2 should **t** Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director. After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatu

Box 68760 Division of Vital Records, P.O.

State

VOH RA 31. Date filed (Month, Day

(Check only

29b. Signature and title of certifier

614 EASTERN SHOKE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MEDICAL LENTER

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2; Date of Death Phyllis Ann Tunnell Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL AT EASTON EASTON Talto Memoral 8. Date of Birth (Month, Day,) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral Year) 944 1 □ M 2 🛣 F 221-28-0795 65 Hours De laware Director Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Federalsburg Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21632 318 Liberty Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married þ within 72 hours after 1 ☐ Yes 2 🔀 No Specify: If Yes Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. Bertha Mae Salvage William G. Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Liberty Rd., Federalsburg, MD 21632 19a. Informant's Name/Relationship (Type, Print) Marvin L. Tunnell/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Hill Crest Cemetery txxx Burial 2 ☐ Cremation 3 ☐ Removal from State 01/27/10 Federalsburg, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee Milla 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Examiner Ob SXMITT Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 2 No __ Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 No 은 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

White

1 Yes 2XXNo

MD

Approximate Interval Between onset and Death

Year

DHMH 17 Rev 7/2009

State

Registrar

219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Le

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31. Date filed (Month, Day, Year)

Norte

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marguerite Virginia Wolford Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Med. Cente Cumberland Allegany 5. Social Security Number **Funeral** . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔯 F Min. (Month, Dav. Year, Country Hours 72 218-34-4485 **Director** 06/15/1937 Maryl Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct MD Allegany Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 11619 Olive Avenue 21502 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed 3 Widowed 4 X Divorced Specify: Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) g James Patrick Carroll Mary Elizabeth 0den permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy V. Wolford / Daughter 12507 Bowling Street, Cumberland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 💢 Burial 2 🗌 Cremation 3 🗍 Removal from State St. Mary's Cemetery 01/18/2010 Cumberland, MD injury 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. Medical resulting in death) Due to (or as a cons Examiner 5 Sequentially flut concludes if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant :
9 Unknown 3 Ectopic pregnancy signed by the atte in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed?

1 Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 Inpatient 2 KeR/Outpatient 3 I DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director: A 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhhammad Naeem, M.D., 625 Kent Avenue, Cumberland, 21502

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)
JAN 15 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMFND#23a1+2perMF, 1/19/10, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:59pm Januaru 2010 Kyi Kyi Win Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday, Funeral 1 □ M 2 🛛 F Hours 0870871932 Burma Director 215-94-3988 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗓 No Derwood Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or Funeral U.S.A 20855 7120 Blanchard Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ō 9 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Specify: "natural", Completed 3 X Widowed 4 Divorced Asian Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygle. Important: If item 27 is marked other 1 any injury or other traumatic event, the once. and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Kyin Maung Ma Mar Ngai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Falls Church. Virginia 22042 7114 Woodley Lane. Kyaw Htin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 01/07/2010 | Brentwood, Maryland Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or o plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate De cause on each line. Cardio Pulmonary, Arrest shock, or heart failure. List Interval Between Onset and Death
Years Immediate Cause (Final Pnysician/ Chronic Renat disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Henorrhagic Shock Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Dialysis Vascular Access Rupture I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last urector: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the hurral. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Left death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Failure 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗆 No ျ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours aft To the Funeral Die eted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

9

ark

9901 Medical Center Dr., Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signat

Deborah Jean Sherrill

31. Date filed (Month, Day, Year)

JAN 19

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 1:14 AM Daniel Wodajo 01 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTH ANENTH HURTHAL Mari Gomes MAKOMA PARK 5. Social Security Number 6. Sex 1 🏻 M 2 🗆 F if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 2, 1961 Ethiopia Months Days Hours Min. Director 063-80-3355 48 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the M dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 735 Sligo Avenune # 312 20910 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 l tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Parking Management Private permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simeneh Bekele <u>Birtukan Admasse</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elias Abebe/ Cousin 1216 Flordia Avenue NE Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 19 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate Of Heaven Silver Spring 2010 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 Part 1 m, r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or part failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATTREVICUONE CARNOVAICULAR DILLOUR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Esia to for as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L P.O. is been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 🗌 Yes 2 🗀 No **Division of Vital** by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner et Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29d. Date signed (Month, Dav. Year) m 01-12-200 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

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32. Registrar's Signature

Are THROMA PARK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02750 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2010 14:49 р м Jessica Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 M 2 XF Min. Aug. 16, 1940 69 Director 164-34-5232 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2X No Ft. Washington Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6606 Southfield Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 X Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Energy Security Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mae Ellis James Freeman Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ft. Washington, MD. 20744 6606 Southfield Rd. Wesley C. Williams - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 1-21-2010 Suitland, MD. 4 ☐ Donation 5 ☐ Other (Specify) Washington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Parl 1. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due t (or as a consequence of) **Examiner** OVOSCULOR DISEOSE 2,0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician ans the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Deage 1 - Yes 2 - No 3 - Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? roentes 1 Yes 2 ANO certificate Yes 2 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P0037066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6185 Oton 141/Fd# 701 Oton 1411, 40 20745 Paigheogu, m.p Uchechi 31. Date filed (Month, Day, State JAN 2 0 2010 Registrar

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

32. Registrar's Signature

10como K

Name and address of person who completed cause of death (Item 23a) (Type, Print)

154422

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 13, Maybelle Edith Wood 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury Solomons Skilled Nursing Calvert Solomons 8. Date of Birth Jan. 19, 7. Age (In yrs. last birthday) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours ^{Year)}1922 1 □ M 2 🔀 F Director 577-26-1983 87 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r ö Funeral U.S.A. Apt. 202 20688 11450 Asbury Circle, death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 No filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 ♥ Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beautician Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file of Health and Mental filem 27 is marked nd Mental marked ပ Edith May Johnson Frank Hall Poe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20688 Daughter P.O. Box 1363, Solomons, Md. Dana Wood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Jan 1 X Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens 4 Donation 5 Other (Specify) Waldorf, Maryland permit. ^{22. Name and Address of Facility} Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, . Signature of Funeral Service Licen M00668 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Ischemia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Pregnant at time of death e detached for P.O. After this certificate has been signed by funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 Yes the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined City or Town, State Medical ie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 610) an usn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

10d. Inside City Limits

Interval Between

Onset and Death

Day

Year

2010

1 Yes 2 XNo

7:30

Country)

A M

DHMH 17 Rev 7/2009

State Registrar David Tardio,

Medical Building, Prince Frederick, Md.

M.D. Calvert Memorial

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Teresa Ann Walsh 11:29 p M January 6, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Emmitsburg St. Vincent Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 201-12-7393 83 Feb 6, Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Emmitsburg Director Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 335 South Seton Avenue 21727 USA within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Religious Community Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; if item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Daughters of Charity 5+ Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Walsh Anna Connell ပ 19a. Informant's Name/Relationship (Type. Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora Anne Signaigo Servant 333 South Seton Ave, Emmitsburg, MD 21727 20b. Place of Disposition (Name of Streemetery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 01/12/2010 Emmitsburg, MD 4 Donation 5 Dother (Specify) Provincial House 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 210 W Main St, Emmitsburg, MD 21727 morai Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** as /Medical Due to (or as a Examiner LUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed the attending physician and thed for use as the burial-tran-Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part/Inother significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probabiy 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending Natural (Month, Day Year) 5 Pending To the Hospire. ... within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide l 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MJL

State Registrar

DHMH 17 Rev 1/2001

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Medi

(Check only one)

29b. Signature and title of certifier

30. Name and address of rerson who completed cause of

31. Date filed (Month, Day, Year) 32. Redistrar's Signature 8 JAN 0

eath (item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Menth LIARY Day 1 21. (2) 12:25W Alice Mary Watson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joseph Medical Center Saint Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours Min. Dec 2. 1932 Marviand Director 220-28-8033 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No <u>Car</u>roll MD Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA 104 Manchester Ave 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☑ No Specify: 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carroll Gardens Nursery worker Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental Hy t; If item 27 is marked oth မ Nellie Helena Yingling Charles Amos Zentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sterling Watson Manchester Ave. Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of Important; If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2010 Westminster, Maryland Meadow Branch Cem. signature of Funeral Service licensee 22. Name and Address of FacilityPritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ METASTATIC CANCER TO BRIAN Medical Due to (or as a consequence of) Examiner ACUTE RESPIRATORY FAILURE Securations if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury UNRESPONSIVE ENCEPHALOPATHY that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes Yes To the Funeral Director; After this certific completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 5 Pending 1 🗌 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier estoponde no NJL D46082 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 TOWSON, MARYLAND 21204 DRIVE OSLER

Registrar

32. Recistrac's Signature

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

P.O. Records, Division of Vital

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JANUARY 2:30 PM 2010 Antoinette Medical Phoebe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hagerstown Washington Washington County Hospital 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral 1 M 2XXF Days oct. 2, 1925 Maryland 84 Director 220-18-2016 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Williamsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 IISA 9 Hopewell Road Apt. H 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 Divorced White the Me iical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Manufacturer 12 Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked ဂ္ Lydia Shipley Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2004 Glen Drive Alexandria, Virginia Michael Ranney-Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of Important: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) <u>Smithsburg Crematory Jan.26,2010 Smithsburg, Maryland</u> 21. Signature of Funeral Service Osborne AdFunerall Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ obstructive disease or condition resulting in death) 0 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) ned by the at 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cancer 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate by 1 🗌 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ဂ္ 1 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the the 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

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State Registrar 31. Date filed (Month, Day, Year)

JAN 32, 2010

32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 01 05 2010 8:25 Ye Fang /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Community Hospital Cheverly Prince Geroge's 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 🖾 F Months Days Director 08/26/1942 China 577-06-0894 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It whedical Examinating must be notified at 10a State 10b. County Director 1X Yes 2 No MD Prince George's Mt. Rainier 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3605 Oak Lane USA Funeral 20712 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2K If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Se p 3 Widowed 4 Divorced Chinese Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Owner Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jian Tam - Son 10435 Rosemount Drive Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 01/16/2010 | Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD Approximate Interval Between Onset and Death METASTATIC LUNG CANCER Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SE 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠ No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) > muxemil Abd RIIA, MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prodella MUKEMil

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 1 9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 1 1 Day 10 **Physician** 10:10A M Geraldine D. Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Sanctuary Burtonsville Montgomery Co. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1□M 2|XF 228-44-7071 77 4/15/32 Virgínia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or Items 23a or ? edical Examiner must be n 14904 Hydrus Road 20906 USA within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black ģ 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Domestic 11th permit. Pages 1 and 2 should be filed very bepartment of Health and Mental Hygis Important: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Howard Deyo Macedonia Fortune ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hawthorne/daughter 3655 Edenderry Dr. Snellville, GA 30039 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Mt ceme@1 1every Bary tlace) CH Important: If it any injury or o Other (Specify) Newtown, Virginia Cemetery 1/16/10 Signat 22. Name and Address of Facility 420 H St. NE BK Henry Funeral Chapel Inc. Wash DC 20002 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complication to shock, or heart failure. List only one callse Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Konse wnic Se uentiall, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed Covonary arteur physician and s the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 donknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has l , page 2 s certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → 10 2 ER/Outpatient 3 DOA မ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 1 Natural 5 Pending 2 No investigation 1 TYes 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.0. Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year) JAN 2 0 2010

EEN

29b. Signature and title of certifier

29a. Certifier

(Check only one)



eted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Denise A. Yingling Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland
5. Social Security Number 6. Sex Allegany Hospital Cumberland 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours. Min. (Month, Day, 54 Ballo. Md **Director** 218-64-4834 06/10/ 1955 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director Wv Mineral Keyser Y Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 98 James Street 26726 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 150 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🙀 ☐ No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Yost Martha Vostrejas 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Street, Keyser WV 26726 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Crematory resaptown,MD 21. Signature of Funeral Serv ²² Name and Address of Facility
Markwood Funeral home
P.O. Box 912 Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause 37 ach line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) P.O. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🔲 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕽 No 1. Sinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

Registrar

State

30. Name and address of

person who completed cause of death (Item 23a) (Type, Print)

261

Memorial Drive Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:50 PM 3010 0 Medical Facility Name (if not institution, give street and a mber, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Saltimore If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Sep 25, 1937 1.8 M 2 🗆 F Months Days Hours Mary land 220-34-5964 72 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster Maryland Carroll 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertalt Hygiene. Important I flem 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the M. iteal Examiner must be any injury or other traumatic event, the M. iteal Examiner must be. Funeral 21157 70 South Church Street, Apt 6 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No
If Yes, Give 1067 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 1967 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Retail Commercial Cleaner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Yingling Augustin Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 70 So Church St, Apt 6, Westminster, MD 21157 Patsy M. Yingling, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01/15/2010 Westminster, MD Westminster Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 utonous Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Right Physician/ ventricle disease or condition resulting in death) days Medical Due lo (or as a consequence of): **Examiner** Tamponade ardiac Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Descendin The law requires that the death certificate be executed and burial-trar resulting in death) Last physician s the burial ntervention Medical Box 68760 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did total

23e. Did total

23e. Did total attending phase as the Physician/ 23d. Date of delivery Month Year signed by the a P.O. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy Disease Myocardial nerforn LOTORKAY ! certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗌 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at □ Natural 5 Pending 1030 AM 2 Accident 3 Suicide Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier **To** t 29d, Date signed (Month, Day, Year) 1151

State Registrar 31. Date filed (Month, Day, Year)

JAN 1

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ne and address of person who completed cause of death (Item 23a) (Type, Print) ココ

32. Registrar's Signature

2010

Jan

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Edward Scott Yingling Month Day Year /Medical January 11:01 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4001 Littlestown Pike, Suite A Carroll Westminscer

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr 13, Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1959 1 M 2 □ F Pennsylvania Director 50 218-72-2641 Usual Residence of Decedent 10a State show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 Littlestown Pike, Suite A 21158 USA Funeral death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No \$ 3 Widowed 4 Divorced Specify: white Completed 16a. Decedent's Usual Occupation 72 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking 12 12 should be filed w h and Mental Hygie. 7 Is marked other tf Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Luther Yingling Pages 1 and 2 should ပ Dorothy Ann Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 permit. Pages 1 and 2 & Department of Health ar Important: If Item 27 is any injury or other trau Nancy Yingling, wife 4001 Littlestown Pike Suite A, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Sengary) crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Carroll Crematory 01/12/2010 Winfield, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 0 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 ☐ Unknown 9 Unknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by pe 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy nerforn this certificate 1 □ Yes 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 MNo Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1∏Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man r of L eat Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hatural Accident 5 Pending investigation death. after death Director: 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifies License number WIL

State Registrar 31. Date filed (Month, Day, Year)

JAN 1

DHMH 17 Rev 1/2001

th (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Per me, g90,02/	Department of Health and N 04/2010dhb Certificate of Death	lental Hygier Reg. I	ne No.2010 02761
	Physici	an	Decedent's Name (First, Middle, Last) Grace Viola Yox		Date of Death Month	3. Time of Death
who or	/Medio	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jan. 11,2	2010 3:49a. M
لمرا			Dove House	Westminster	O. Date of Dieth	Carroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 M 2 XF 85	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 11/13/192	9. Birthplace (State or Foreign Country) MD.
	land ow II		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	e Mary 3a-f sh	Director	MD Baltimore Ham	pstead		1 □Yes 2X No
	th with th	al Dire	10e. Street and Number 5130 Black Rock Road	10f. Zip Code 21074		Citizen of What Country? USA
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exambra instructions to conflict at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0	ithin 72 ho ne. han "natu Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	Kind of Business/Industry
d 21	filed withi Hygiene. other thar ent, tre		17. Father's Name (First, Middle, Last)	clerk 18. Mother's Nam	e (First, Middle, Maid	andom House Surname
ylan	should be find Mental in marked of umatic eve	To Be	Leonard Royal Walter	Lesney S	Sybilla He	intzman
Maryland	nd 2 sho alth and I 27 is ma er trauma	0.0		. Mailing Address (Street and Number or Rui .O. Box 11, Boring, M		ty or Town, State, Zip Code)
nore,			20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of cemeter	f Disposition (Name of ry, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) St. P 21. Signature of Funeral Service Licensee M00741	22. Name and Address of Facility	Eline Fune	eral Home
			23a. Part 1. Enter the disease, or complications that caused the death. Do	934 S. Main Street,		Approximate
mi de	Physician /Medical Examiner		shock, or heart failure. List only one cause to each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	PANIAL HER	lorehag	Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	ofj.	1 EVALUNER	
68760,	ificate be executed g physician and is the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence	of): CERTIFICATION APPROVED B	MEDICAL EXPERIMENT	
	rtificate ng phy	Medical	IF FEMALE:			
.O. Box	The law requires that the death certif ste has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	- 27 2 4	23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 P Unknown
of Vital Records,	ician: The law r certificate has be ector, page 2 sh	Completed			24a. Was an autopsy performed 1 □Yes 2 □	
f Vit	lis dir	To Be	25. Was case referred to medical examiner? 1 ▼Yes Hospital: 1 Inpatient 2 ER/Ou	Other	h (Check only one) me 5 Residence	6 Pother (Specify) HOSDICE
	ding Ph h. After th funeral	ion:	1 ✓ atural 5 ☐ Pending (Month, Day, Year)	Time of 28c. Injury at njury Work?	28d. Describe how in	
Division	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.			
	To the within 2 To the comple	Me	29b. Signatural and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)
	dfr		30. Name and address of person the completed cause of death (Item 23a)		Actual)Ster, M) 21157
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 12 2010 32. Registrar's Signature	park	, <u>, , , , , , , , , , , , , , , , , , </u>	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan
				- #		

10-00648 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Craig Armstrong 1. For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle,Last) Physician/ Month 0350 hrs January 22, 2010 **Medical Examiner** Craiq Armstrong 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Brooklyn 3935 Brooklyn Avenue N/A If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Country) MD 1 XM 2 F Yrs 10-13-1967 212-82-0274 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 'n 10a State 1 X Yes 2 No 'natural", or items 23a or 28a-f shov Examiner must be notified at once. Brooklyn death with the Maryland rector 10f. Zip Code 10g Citizen of What Country? 10e Street and Number Ö 3935 Brooklyn Avenue 21225 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 2 X No Yes 1 Yes 2 No specify: filed within 72 hours after If Yes, Give Year Specify: Black 3 Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) Itimore, MD 21215-0036

it. Pages I and 2 should be filed within 72 ho
trament of Health and Mental Hygiene.
ortant: If item 27 is marked other than "na
yor other tranmatic event, the Medical Exyor other tranmatic event, the Medical Ex-College (1-4 or 5+) Flementary/Secondary (0-12) Disabled N/A 11th Grade 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Jaemson Armstrong Barbara Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3935 Brooklyn Ave., Baltimore, MD 21225 Barbara Jakubik(Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition JOSEPHOBYCON F/H Burial 2 Cremation 3 Removal from State 02/05/10 And Crematory Baltimore, MD Domation 5 Other Specify ²²Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., BAltimore, MD 21. Sign fure of Service License 21217 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and iller e. List only one cause on each line /Medica/ Death Acute bronchopneumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED 23a, PII, 27, 28a-f, per ME g903 5/13/10 TT X UNPENDED physician the burial certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ö Yes 2 No 3 Probably 4 V Unknown þ σ. Seizure disorder of unknown etiology Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✓ Other Scene ER/Outpatient 3 DOA this 1 🗸 Yes 28a Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work After 27 Manner of Death Certification: Natural 1 Yes 2 Pending Director: unk unk Investigation Accident 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) unk 4 Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifie 29c. License number

Ø V

State 31. Date 15 16 17 18 20 18 Registrar

Patricia Aronica-Pollak MD

Assistant Medical Examiner

O.C.M.E.

January 22, 2010

30 Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Robert Arrington Month feb 658 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year) 213-54-3316 61 Director 12. 1949 MD Jan. Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 4669 Falls Road 21209 USA should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married \$ 1 X Yes Specify: Black 1 Yes 2X No Specify: Baltimore, Maryland 21215-005. If Yes Give 3 ☐ Widowed 4 K Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 unkn unkn. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Johnson Lloyd Arrington Hattie other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2300 N. Calvert St. Apt. 303, Baltimore, MD 21218 Page 1 and 2 sl ment of Health a Tiffany R. Arrington / Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Final Journey Crem. 9 1 Burial 2 Cremation 3 Removal from State Department Important: If any injury or 2/3/2010 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services Marsha W 1413. Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 25 Minutes Medical Due to (or as a consequence of) Examiner Sacuentally 1st conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Medical that the death certificate be Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 2 No 3 Probably 4 Unknown 1 Yes been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 🗌 No 1 Yes Yes r this certificarial director, I Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 2 - ER/Outpatient 3 - DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💢 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 5 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 243 89 46 Young car 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD/ Mark Young, MA

Registrar

State

31. Date filed (Month, Day, Y

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Mary		artment of H rtificate of L			giene 2 (010	02764
Physic /Med		Decedent's Name (First, Middle, Las	Jacqueline	Parks	Alderson	1	2. Date of Dea Month Januar	y 29, 2	010	3. Time of Death 9:04 P M
Exam		4a. Facility Name (If not institution, give 8005 Kerry Lane		land hintledge. N	Chevy	Chase If Under 24 Hrs.	R Data of Birt		tgome	
Funera Directo		370-20-2037	ox 7. Age (// □ M 2 🛱 F 82	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da April 1	y, Year) 1, 1925	Washin	lace (State or Foreign htry) gton, D.C.
aryland show	o.	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	ŧ.	c. City, Town or Lo	ocation ry Chase				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
th the M or 28a-f	Funeral Director	10e. Street and Number	J. II. C. I. Y	- One v	10f. Zip Code			10g. Citizen of	What Coun	try?
23a c	ra D	8005 Kerry Lane			2081			United		
Dattimore, Marylating Z.I.Z.I.3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it all edicit Examination of the confined at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 🛣 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	- 14. Ha Bla Speci	ce - Americ ick, White, e fy: Wh	
LIS-0-10-10-10-10-10-10-10-10-10-10-10-10-1	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired omemaker	ation during most of work)	sing	16b. Kind of E		lustry
Hygier Ther th	S	17. Father's Name (First, Middle, Last)	44		omemaker	18. Mother's Nam	e (First, Middle,			
yland wild be file Mental H arked oth	To Be	1	irks					Ottes		
Mar nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (7 John G. Alderson	· ·	l l	ng Address <i>(Street a</i> Oak Avenu					
es 1 ar of Hea of Hea r other		20a. Method of Disposition	2	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	e) Febr	Date uary	20c. Location	- City or To	wn, State
Datumor Dermit. Pages Department of mportant: If its my Injury or o		1 ፟ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		emorial Parl	$\langle 3, 2 \rangle$	010			Maryland
Dermi Depar Impor	once	21. Signature of Funeral Service Licen	not MC	11303 75	57 Wisconsi	n Avenue, l	Bethesda,	Maryland	-Chevy 1 20814	
∼ Physiciai ⊢ /Medica Examine	al	23a. Part 1. In fer the disease, or come shock, if heart failure. List only Immediate Cause (Final disease or condition resulting in death)		11 Ce11 I	ter the mode of dyin		or respiratory a	rrest,	3	Approximate Interval Between Onset and Death Months
ficate be executed ficate be executed physician and streets the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter binderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co							
icate be exphysician by the burial	dical		.d							
THECOTICS, P.O. BOX OF The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	□ Ectopic pregnanc □ Other (specify) _	у			ate of deliver	ery Day Year
ecords, F. law requires that as been signed b 2 should be deta	ğ	, i an in onion organicani contantono c	ontributing to death but n	ot resulting in the u	underlying cause give	en in Part I.				he cause of death? bably 4 ☐ Unknown
ate Th	Completed						24a. Was auto perfo 1 □Yes	nsv	. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
OT VITAL Physician: T this certificat ral director, pa	Be (25. Was case referred to medical examiner?	Hospital:		ont 3 DOA Oth	26. Place of Dea				
F F Sile	P.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	SUL STI DON	4 LI Nursing H	ome 5 🕅 Resi 28d. Describe	dence 6 0 how injury occu		<u>'y)</u>
sion arh. r: Afte	atior	1 Natural 5 Pending 2 Accident investigation		ear) Injury		k? Yes 2 □ No				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Rura	al Route Number,
e Hospit 24 hour e Funera letely filla	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or i						
To th within To the	Me	29b. Signature and title of certifier	126		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
		furfuly.	N Don 1	ul)		2775		Februa	ry 1,	2010
		30. Name and address of person who Frederick G. Barr				ie, #1300	, Chevy	Chase,	Mary	land 20815
Panis	State	31. Date filed (Month, Day, Year) FEB 0 3 2010	- 0	Signature						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b-c, State of Maryland / Department of Health and Mental Hygiene State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Vear 0748 Jonah W. Brandon Februar 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** (Month, Day, Year) Min. 1 ➡ M 2 □ F 216-02-4745 44 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Completed by Funeral Director N/A Baltimore 1X Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 2804 Walbrook Ave ŬSA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status African 1 ☐ Never Married 2 🔀 Married 1X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) New Psalmist Elementary/Seconday (0-12) College (1-4 or 5+) Executive Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 20llie P. Brandon Wade Brandon Braildon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 2804 Walbrook Ave, Balt., MD Jacquetta Conwell-Brandon 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
King Memorial Park $\frac{2}{3/6/10}$ Owings Mills Baltimore, MD , Ma 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature of Fineral Sirvice Linins ^{22. Name and Address of Facility}Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) nemorrhage Intracrania Medical Due to (or as a consequence of) Examiner 17 days tension Sequentiany list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completed filled in by the funeral director, page 2 should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown morbid obesity, congestive Heart Failure 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 1 🗆 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinci Hospital of Baltimore, 2401 W. Belvedere Ave, Baltimore MD 21215 Dordlinger, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 03 Registrar

DHMH 17 Rev 7/2009

Jonah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G900, 2/18/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician /Medical 1945 Marchessa 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 217-34-6645 Days **Director** Jsual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Yes 2 □ No Funeral Director 10g. Citizen of What Country? Street and Numbe Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 Yes þ 3 Widowed 4 Divorced "natural" Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. condary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surr Be is marked of 19b. Mailing Address (Street and Number 19a. Informant's Name/Relations nt of Health : 20a. Method of Disposition

Burial 2 Cremation

Donation 5 Other (\$ /2010 3 Removal from State Department of Important: If any injury or once. 5 🗌 Other Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) /Medical o (or as a con **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner lor Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Dav Pregnant at time of death 5 Other (specify) signed by the a Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 🗌 No 1 Yes 1 🗌 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death Certification: 1 Natural
2 Accident 5 Pending investigation Injury 1 🗌 Yes death. after death 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined e Funeral (Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

For

		1 = State Registrar			Certificate of	Death	Re	g. No.2	J U216
Physic	ian	1. Decedent's Name (First, Midd	•				2. Date of Death Month	n Day Yea	
/Med			Ollie Mae	Bowers				n 28, 2010	2:00 P M
Exami	ner	4a. Facility Name (If not institution	n, give street and number) Id Montgomery Ro		4b. City, Town, o	or Location of Death Columbia	1	4c. County of D	
Funero		5. Social Security Number		e (In yrs. last bir	thdav) If Under 1 Year		8. Date of Birth	9.1	Howard Birthplace (State or Foreign
Funera Director		217-26-5001 Usual Residence of Decedent	1□M 2XF		Yrs. Months Days	Hours Min.	(Month, Day, May 1	Year)	Country) W. VA
/land		10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits
e Mary Ba-f sh	Director	MD	Howard			Columbia			1 □ Yes 2 XNo
ath with th	ral Dire	10e. Street and Number 8291 Old Montgom	ery Rd.		10f. Zip Code	21045	10	g. Citizen of What	Country? J.S.A.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examic must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		13. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 □ No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
72 ho	eted	15. Deceder	nt's Education est grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	pation during most of work	kina 1	6b. Kind of Busine	ss/Industry
vithin sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use retire	nemaker		Ow	n Home
filed v Hygie	ပ္သိ	12 17. Father's Name (First, Middle,	Last)			T	ne (First, Middle, M		II HOME
uld be Mental Irked o	To Be	, , , , , , , , , , , , , , , , , , , ,	Loney Lawerence	e Smith				eka Smith	
nd 2 should be file lith and Mental Hy 27 is marked oth r traumatic event	ľ	19a. Informant's Name/Relations Richard Bowers	1 1 21		. Mailing Address (Street			*	e, Zip Code)
Deficiency (E.) Department of Heal Mportant: If item (in) injury or other me.	1 3	20a. Method of Disposition			f Disposition (Name of ry, crematory or other pla			t0c. Location - City	or Town, State
Page nent c int:		1 Durial 2 □ Cremation 4 □ Donation 5 □ Other (5	3 ☐ Removal from State Specify)	1	owridge Memorial	i - .	01, 2010	Elkridg	je, Maryland
permit. Departr Imports any inju		21. Signature of Funeral Service	Licensee	0.3	22. Name and Addre				
0 82586		MULLINE	1 FILLER	101295	3871 OI	uneral Home, I d Columbia Pi	P.A. ke Ellicott Cit	y, MD 21043	
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do / ou, tificate be exe g physician a as the burial-i	/Medical		d						-
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uires that the de	þ		POLESTER	DL,	,	ven in Part I.	23e. Did tob		e to the cause of death? Probably 4 Unknown
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sician: The certificate h rector, page	BeC	25. Was case referred to medica				26. Place of Dea	1 ☐ Yes 2 th (Check only one		res 2□No
hysic his ce I direc	2	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Ou	tpatient 3 ☐ DOA Oth	ner: 4 🗆 Nursing H	ome 5 Resider	nce 6 Other (S	Specify)
ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 ☐ Pendin		ry 28b. 1 <i>I, Year)</i>	Fime of njury 28c. Inju		28d. Describe how	w injury occurred	
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely illied in by the funeral director, page 2 should be detached for the completely illied in the control of the completely illied in the control of the completely illied in the control of the completely illied in the control of the completely illied in the control of the completely illied in the control of the completely illied in the control of the control	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not ho	iry - At home, fa <i>(Specify)</i>	M 1 ☐]Yes 2□No	28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
he Hospita in 24 hours he Funeral pletely fille	Medical C	29a. Certifier (Check only one) Certifyin 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner sta	examination an	e, death occurred at the t	ime, date and place opinion, death occu	e, and due to the ca erred at the time, da	tuse(s) and manne te and place, and d	r as stated. due to the cause(s)
To ti withi To ti	W	29b. Signature and rife of certifie	/ \ - / / /	in, M.	+	15403	v		2010
5		30. Name and address of person	who completed pause of de	ath (Item 234)	TYPE Print) ENS 1	AVENNE	E, BAL	TIMOR	E 1229

State Registrar

31. Date filed (Month, Day, Year)-

ORIGINAL

511

State 31 Date filed (Month, Day, Year)
Registrar FER 0 3

Theodore M. King, Jr., MD.

Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

	1	d #8 per Fh G901 3	Glate of Ivial ylan	Cer	tificate	of L	Death	ALIGI IV	orrar 11	Reg. No		02769
		1. Decedent's Name (First, Middle, Las	t)				_		2. Date of D			3. Time of Death
hysicia /Medic		Richard K	. Carter						Feh	1,	2010	11:55AM
xamin		4a. Facility Name (If not institution, give	street and number) LOCH Rawan	Blod	Bo	eltru	Location				County of Dea	/A
neral rector		210-10-1044	7. Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D	irth 8/2 Pay, Year) /24	4/22 9. BI	rthplace (State or Foreign country)
show d at		Usual Residence of Decedent 10a. State 10b. County MD Baltime		y, Town or Loc Kesvil							-	10d. Inside City Limits 11 Yes 2 □ No
or 28a-r	Director	10e. Street and Number			10f. Zip	Code 212	0.0			10g. Ci	tizen of What C	country?
an natural, or hems 23a of 20an show Madical Evanimer wast be notified at	ral	10 Tentmill Lar 11. Marital Status 1 図Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give			lent of H cify Cuba			ecify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Wh Africa Specify:	ite, etc. 1 N
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ic event,	To Be (17. Father's Name (First, Middle, Last) Clarence Cart	er						. Car		n Surname)	
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Important; if he any Injury or of once.		21. Signature of Fun ral Service Cer	isee	22	2. Name an	ad Addre Bel	ss of Facili .air	Ha Rd,	ri P. Balt.	Clc ,MD	se F. 21206	Svs, PA -5105
icían dícal miner	iner	23a. Part 1. Effer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):	Syn				or respiratory	arrest,		Approximate Interval Between Onset and Death
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has been s je 2 should	Completed	DESMENT.							24a. W	as an topsy rformed?	prior	autopsy findings availab to completion of cause o
After this certificate h funeral director, page		25. Was case referred to medical	MECHIUS	THRE	2		26. Plac	e of Dea	1 □ Yes	2 AT	lo 1 🗆 Y	es 2 Mino
nis cer direct	o Be	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	nt 3 🗆 Do	OA Oth	2011	_			6 □Other (S	Specify)
To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be]No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,				
To the Funeral Director: completely filled in by the		4 Homicide determined	building, etc. (Spec	owledge dea	th accurred	at the t	ime, date :	and place	City or	Town, Sta	ite)	r as stated.
To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exa	miner: On the basis of examir and manner stated.	nation and/or in	nvestigation	n, in my	opinion, de	eath occu	rred at the tin	ne, date a	no place, and	oue to the cause(s)
To t	Ž	29b. Signature and life of certifier	P. man .	V.1			se number				ate signed (M	onth, Day, Year)
			completed cause of death (Ite RING ALVA 32. Registrar's Sign 2010	KC TUZ		1/	20'	> 10	-		41/1/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Day **Physician** rosb 2n10 /Medical c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth 3-23-1 last birthday) If Under 1 Year **Funeral** Days Min. 1 □ M 2 💢 F Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be notified at once. 10d. Inside City Limits City, Town or Location 10a. State 1 ☐ Yes 2 WNo Funeral Director atonsv:lle 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21228 ISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Blac Specify þ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Be 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Ba 'Ao' 101 trances Ka Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 aure! laryland ationa of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hyper halemia Physician un known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failer Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed VOLVULUS the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Physician: The 2 No 1 ☐ Yes 1 ☐ Yes Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 50297 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ED AGNUCS 32 Registrar's Signature 31. Date filed (Month, Day, Year) State COVEN) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ae Cunninghar		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	02771
Physicia ledical Exami	ın/	n/ 1. Decodent's Name (First, Middle, Last) 2. Date of Death Month Day Year	Time of Death 1802 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Northwest Hospital 4c. County of Death Randallstown Baltimore Count	v
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthp Foreign	·
Director		212-22-9716 1 M 2 SF 91 Yrs. Months Days Hours Min. 08 09 19 18 Count	n) SC
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ith the N 23a or 2 notified	al Dir	3018 St. Lukes Lane 21207 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American	Indian Black
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21215-0036 hould be filed within 72 hours after death with the Maryland and Marlal Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked ther than "natural", or items 23a or 28a-f sho itic event, the Medical Examiner must be notified at once.			010
2121 ould be fil I Mental B s marked ic event,	To Be		pc@1117
ME and 2 s salth au 27 raums		Bernice Brown (Daughter) 10406 Cascade Falls Ct., Owings Mills 20a Method of Disposition (Name of cemetery, Date 20c. Location - City or To	M.D wn, State
		1 Burial 2 Cremation 3 Removal from State Genatory or other place) 4 Donation 5 Other Specify: Quenatory or other place) 4 Donation 5 Other Specify: Quenatory or other place) 4 Donation 5 Other Specify: Quenatory or other place)	e, mo
Baltimo permit. Page Department o Important: injury or out		22. Signature of Funeral Service Licenses 22. Nation and Activess of Pacifity Greene Funeral Service Licenses 32. Nation of Pille (2/2/2)	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
	Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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or ut att	sicia	past 12 months? 1	100.
the o	F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	
	ted by		sy findings available
of Vital Records, ig Physician: The law requirement is certificate has been someral director, page 2 should I	Completed	autopsy prior to comperformed? 1 ✓ Yes 2 No 1 ✓ Yes	pletion of cause of
ital Reco	Be	25. Was case referred to medical examiner? Hospital: 4 Inpution 2. EP/Outpution 3 DOA Other Nursing Home 5 Pesidence 6 Other Other 1	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Test Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ause(s)
F % F 3	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, O.C.M.E. January 31, 2010	Day, Year)
101		30. Name and address of person who completed cause of death (Item 23a)	
10,	ate	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Legistrar's Signature	
Regist			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Sa 525M 2010 William 27 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) Berlin Year | If Under 24 Hrs General Worchester 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 1 M 2 □ F Yrs. 578-38-3544 Usual Residence of Decedent Director Dec 24, 1938 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If flean 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, if a "safes E winner must be notified at 1₽Yes 2□No Director Norceste ean 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S.
Armed Porces?
1 Dives 2 | No Navy
If Yes, Give
Year or Dates: 21843 USF by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter 13 ommercia Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dr. Ocean City, MD Dateurk 20c. Location - City Town, State hristopher -ole Baltimore, 20a. Method of Disposition Date WK 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) etro Baltimore, MD 21. Signature of suneral service Licensee 22. Name and Address of Facility Sesson PA
Appr ximate
Interval Between
Onset and Death IAM 1232 Midvalley Dr. 23a. Part H. Enjet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia Cause (Final disease or condition a. Matarta particular Caucum death)

a. Matarta particular Caucum death) Immedi J. Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner One to for sels consequence of and the burial-trar Due to (or as a consequence of) the attending physician the for use as the buria Box 68760. certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ď signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₽ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed? res 2 No certificate Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ō this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending F 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Mospital within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

24 1.9

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0 0 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Van Egmond MD, Alluntic General Hospital, 9733 Healthway Drive, Berlin, MD 21811

D0056307

29q. Date signed (Month, Day, Year)

and manner stated

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 28, 2010 9:39 Canfield Рм Virginia Richardson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye December 8, . Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days 1919 Massachusetts 90 012-14-1467 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f show the Medical Extended at 1 ☐ Yes 2 X No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12316 Coppola Drive 20854-3030 United States Funeral filed within 72 hours after death I Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public High School 5+ and Mental Hygi permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. Richardson Harvey Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12316 Coppola Drive, Potomac, Maryland 20854-3030 Norman L. Canfield /Husband 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2, 2010 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Inge (atto Barent M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Ischemic Cardiomyopathy Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 certificate be Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation after death.

I Director: Af ed in by the fu 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

P.O. Records, of Vital Division within 24 hours a To the Funeral C Hospitai

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patsy McNeil, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's FEB 0 3 2010

Registra

one)

29b. Signature and title of cent

29c. License number

D62553

29d, Date signed (Month, Day, Year)

January 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:45PM Monique 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Battimone IOWSON Hospice 7. Age (In yrs. last birthday) Security Number If Under If Under 24 Hrs. Year 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months Days 218.92.990 1 □ M 2 X F MD Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Baltimore 28a-f 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country Funeral 2712 Boarmar tvenue items 23a i and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) life. DO NOT use retired Nationwide insurance 1eavs Be 17. Father's Name (First Middle Last s Name (First, Middle, Maiden Surname) ပ Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wenue Baltimore MD 21215 Boarman 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Windsor Mill 05/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee gan O. Greene Funeral Services 22. Name and Address of Facility Van Randallstown, MD 21133 23a. Part 1. Enter the it sease, or complications that caused the death. Do not enter the mode of dying, such as included as i Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ with disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): e attending physician and for use as the bunal Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 2 No 1 Tes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 9 Hospital or Attending Physician: The law r 124 hours after death. 16 Euneral Director, After this certificate has the Funeral Director, After this certificate has the fineral director, page 2 ? 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No 1 Yes Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. roleted (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month UZ **Physician** 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HaHiMore Parkway Wildwood If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day Social Security Number 7. Age (In yrs. last birthday) **Funeral** 86 Days 226-20-6797 Usual Residence of Decedent 1 XM 2□ F Yrs. Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or itama 23a or 28a-f show vant, the Middical Examinat must be notified at Baltimore 1XYes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Ever in U.S. 14. Race -11. Marital Status t Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: ۵ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2+h Coltege (1-4or 5+) perator permit. Pages 1 and 2 should be file Depertment of Heath and Mental Hy important: if item 27 is marked oth, any injury or other traumatic avant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Silas tannie. 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre-t and Number or Rural Route Number, City or Town, State, Zip Cod-) Date 20a. Method of Disposition Stav 21. Signature of Funeral Service Licensee Greene FS / Baitimore, 1 23a. Part1. Enter the isease, or complications that caused the death, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enterme mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Va **Physician** inknown /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien end I for use es the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 1 Yes 2 No 5 Other (specify) certificete has been signed by the rector, page 2 should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Tyes 2 □ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to comptetion of cause of death?

1 □ Yes 2 □ No autopsy performe 1 ☐ Yes 2 No : After this certifice e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural Injury 5 🗌 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2 ause of death (Item 23a) (Type, Print) 30. Name and add 31. Date filed (Month, Day, Year FEB 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOYCE ANNE DAVIS Month 10p 2010 M Medical JANUARY 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CASEY HOUSE NURSING CENTER ROCKVILLE MONTGOMERY curity Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min. 184-38-1308 63 Director 0 - 28 - 1946PENNSYLVANTA Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f MD. PRINCE GEORGES UPPER MARLBORO 1X Yes 2 ☐ No 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 5605 SOUTH MARWOOD BLVD APT 327 20772 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ò چ 1 Never Married 24 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: AFRICAN-AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working r than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CONTINUITY MANAGER RADIO marked other filed Be 17. Father's Name (First, Middle, Last) And Page 1 and 2 sho.

Yent of Health and Me.

'titem 27 is marked v.

'r traumatic ev. 18. Mother's Name (First, Middle, Maiden Surname) ၉ HAROLD B. TATE BERNICE DURANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5605 SOUTH MARWOOD BLVD APT 327 UPPER MARLBORO, MD WILLIAM HENRY DAVIS III (HUSBAND) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) CHELTENHAM VETERANS 2-10-2010 CHELTENHAM, MARYLAND MAHT ANOTOS HIBN R2. Name and Address of Facility MAJOR H. WINFIELD FUNERAL HOME, INC D, 704 N. FRONT ST. STEELTON. 23a. Pa Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so the failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final Physician/ INTRACEREBRAL HEMMORAGE dis are or condition resulting in death) Medical Due to (or as a consequence of) Examiner DUN SUBDURAL HEMATOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of, signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed TRAMATIC BRAIN INJURY Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ BILATERAL TIBIA/FIBULA FRACTURES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No After this certificate 2 No Yes 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 1 Yes 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 🖾 No Investigation Could not be 12/28/2009 08:45a ^M 24 hours after deat Funeral Director: STRUCK BY VEHICLE Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined PUBLIC STREET 1818 CHAPMAN AVE. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar

BINOV

31. Date filed (Month, Day, Year)

MUNCASTER MILL RD, ROCKVILLE,

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH 6001

MD33755

MARYLAND

29d. Date signed (Month, Day, Year)

FEBRUARY 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernard C. Edelmann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Battimore If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Davs Hours Min March, Day, Year 42 Maryland 214-40-2439 67 Director Usual Residence of Decedent pern it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy njury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director Balto. Md. Nottingham 1 🗌 Yes 2 💢 No 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 4614 Beaconsfield Drive USA 21236 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 9 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Widowed 4 Divorced Year or Dates White Maryland 21215-00 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Xerox Service Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard C. Edelmann, Jr. Esqualine Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21236 4614 Beaconsfield Dr. Nottingham, Md. Kathleen Edelmann Spouse timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State نة N Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 2-5-2010 Balto.Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek, Funeral 9705 Belair Rd. Nottingham, Md. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MINUTE. Medical resulting in death) Due to (or as a consequence of) Examiner 30 minute Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 V No ဂ 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 IVE Baltimore MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registra's Signature

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		1- For State Registrar	C	ertific	ate of De	ath			Reg. No	2010	02//
Physic							-	2. Date of De		V	3. Time of Death
ledical Exam	iine	COMMIT			EISE	NSTE:	IN	January	26, 20	Year 10	1612 hrs
		4a. Facility Name (if not institution, give	street and number)				or Location of Dea	ith		c. County of Deat	
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birt		nder 1 Ye			Birth(MM	1/DD/YYYY) 9. Bi	thplace (State or
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		Usual Residence of Decedent							0, 13	,,,,,	110
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faryla 28a-f	Director	10e. Street and Number				Zip Code			10g. Cit	tizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once.	늅	11403 MARBROOK RO	AD				21117	Í			USA
with ns 23	eral		12. Was Decedent Ever in	U.S.	13. Was Dece	dent of H	ispanic Origin? (Specify Yes or N	lo-	14. Race - Amer	ican Indian, Black,
Jeath riten	ľŠ	1 Never Married 2 X Married	Armed Forces?		If Yes, spe	cify Cuba	an, Mexican, Puer	to Rican, etc.)		White, etc.	
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2121 uld be fi Mental I marked	Be	PHILIP			ALL		ROSE				CHMAN
MD 21215-0036 d 2 should be filed within 7 tth and Mental Hygeiene. n 27 is marked other than numatic event, the Medica	욘	19a. Informant's Name/Relationship (Type		100						ity or Town, State	
		MYLES EISENSTEIN 20a. Method of Disposition	/ HUSBAND]	1403 M/ Disposition (N	ARBRO	<u>OOK ROAD.</u>			LLS, MD	
Ore esla of He If its		1 X Burial 2 Cremation 3	Removal from State	. Place o AdRelma[td	MGTON PIEC	ame of ca ₽MET	ERY	Date	20c.	Location - City or	Town, State
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Baltimore, permit. Pages 1 an Department of Her Important: If ite		21. Signature of Funeral Service Licenses)		22. Name ar	nd Addres	s of Facility SOL	LEVINS	SON	& BROS.,	INC.
	┝) stro / d			8900 F	REIST	ERSTOWN	ROAD, F	IKE:	SVILLE,	
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	ē	Sequentially list conditions, if any, leading to immediate Due	e to (or as a consequence	of):					_		
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E B C	Examiner	events resulting in death) Last Due	e to (or as a consequence	of):		_					
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776 ficate g phy s the t	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre	gnancy					230	d. Date of delivery	
certi certi use a	cial	past 12 months?	4 Pregnant at time of d	eath 5	Fetal deat		Ectopic pregn	ancy		Month D	ay Year
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e law	E D								rmed?	death?	ompletion of cause of
T. Th		25. Was case referred to medical				20 Diane	of Dardy (Charle	1 Yes	2 N	0 1 🗸 Ye	s 2 No
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by tuneral director, page 2 should be detach	Be	examiner? IHost	pital. 1 Inpatient 2	ER/Out	patient 3	DOA	of Death (Check Other, Nursi		Danida	nce 6 🗸 Other	Page
1 of V ding Phy After th funeral d	<u>۱.</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	_	me of Injury		ry at Work?	28d. Describe			Scene
	틸	1 Natural 5 Pending	(Month, Day, Year)	İ			Yes 2 No			ary occurred	
isic	ig	2 Accident Investigation	28e. Place of Injury - At h	nome, fari	n. street. factor			28f Location (Street a	nd Number or Rur	al Route Number, City
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact	Certification;	3 Suicide 6 Could not be determined	(Specify)	,	,	,,	unanig, ota	or Town, S		rid rediriber of Ital	ar Route Number, City
Hospi 4 hou Funer ely fil		20a Certifier	To the best of my knowled	dae deat	n occurred at th	e time d	ate and place, and	due to the caus	20/2) 20/	d manner en state	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On	the basis of examination a	and/or inv	estigation, in m	ny opinion	, death occurred	at the time, date	and pla	ce, and due to the	cause(s)
T. W. C. D. D. D. D. D. D. D. D. D. D. D. D. D.	§ €	29b. Signature and title of certifier	d manner stated.		29	9c. Licens	e number		29d. [Date signed (Mon	th, Day, Year)
101		Deland B. W.	11 211)			O.C.I	M.E.			uary 27, 2010	, ,
ana	}	30. Name and address of person who com	pleted cause of death (Iter	1 23a1							
Oth.			ssistant Medical Exa		111 Penr	n Street	t, Baltimore, N	MD 21201			
	ate	31. Date filed (Month, Day, Year)	32. Registrar Signat		de						<u></u>

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ONOTHRY MARY GLINDA ESTREMSKY 2 Xear 0 27:47A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical imore Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 212-18-2946 1 □ M 2 🔽 F Hours . 1926 Marvland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore County 1 ☐ Yes 2 ♣ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 521 Charles St. Avenue 21204 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 Yes 2 XXNo Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify: Specify: White XX Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 VTS Collega (1-4 or 5+) Secretary Jay Strong Law Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Blucher Florence Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley F. Estremsky lll 2202 Exeter Ct. Fallston, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Incl 1~28~10 Baltimore, Md. 4 Donation 5 Other (Specify) 7401 Belair Rd. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONORY disease or condition resulting in death) Due to (or as a consequence of): DISEASE EXACERBATION if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): PRINTED DESCRIPTION OF THE TURING

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

þ

Completed

Be

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Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

72 hours after

and Mental Hygiene. is marked other than

permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once.

traumatic event,

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed

physician and s the burial-transit use as signed by the atte Certificate: To Be 24 hours after death.
Funeral Director: After this eted filled in by the funeral of

Medical

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

the Hospital or Attending Physician: The law requires that the death certificate be executed

After this certificate

Division of Vital Records, P.O. Box 68760

that initiated events resulting in death) Last	c	
	d	
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknow	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1
25. Was case referred to medical examiner?	26. Place of Death (Ch	
1 Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no		28d. Describe how injury occurred
4 Homicide determine	1 28e Place of Injuny - At home form street factory office	28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D52749

OSLER DRIVE

TOWSON MARYLAND 21204

29d. Date signed (Month, Day, Year) 01-27-10

City or Town, State

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 4:30 PM William Harry Gill Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u> Carroll Hospital Center</u> Carroll Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Y D. 26, 1XX M 2 □ F Months Days Hours Min. Director 189-22-4778 79 .930 Pennsylvania Sep. Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director XX Yes 2 ☐ No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examiner must be 1 10g. Citizen of What Country? by Funeral United States of America 3260 Grafton Street 21102 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? No 1949-Black, White, etc. 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: 3 Divorced Completed 1970 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) llth United States Air Force Sergeant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Gorrell Gill Katherine Henrietta Harlor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gill (Son) 2314 Old Fort Schoolhouse Road, Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Feb. 4 Donation 5 Other (Specify) 2010 Manchester, Maryland 21. S nature of Fun 1 Service License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nediate Cause (Final Onset and Death Physician 0 disease or condition Medical resulting in death) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and I for use as the burial-transit UM Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed' After this certificate 1 ☐ Yes 2 ☐ No 2 1 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident
Suicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my kirowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MI) 02-01-2010

State Registrar MEMORIAL

AVE

WESTMINSTER

MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

92 Pegistrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per Inf G907/9/23/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 31. 2010 Shashi A. Gupta Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Hospice Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea February 25 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F Director 54 229-04-7194 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location Director Florida Maryland Orange, Winter Park Potomac 10f. Zip Code 10g. Citizen of What Country? 350 Carolina Avenue Apt 202 Funeral 32789 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗓 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Saraswati Devi Jugal Kishore Gupta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9004 Congressional Court, Potomac, Maryland 20854 Dr. Jai N. Gupta/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Feb. 2, 2010 Bethesda, Maryland 21. Signature of Funeral Softige Licente Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Harm M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Breast Cancer disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burial-transit that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Be Completed by

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

dical	L C	d						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23d. Date of delivery Month Day Year						
þ	Part II. Other significant conditions co	use contribute to the cause of death?						
Completed		24b. Were autopsy findings available prior to completion of cause of death? No 1 \sum Yes 2 \sum No						
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
2	1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	ome 5 Residence	esidence 6 X Other (Specify) Hospice				
Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		work?	28d. Describe how inju	ry occurred			
	4 Homicide determined	28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)				
Medical	(Check 2 U Medical Exami	and manner as stated. e, and due to the cause(s) and manner stated. (s) and manner as stated.						
	29b. Signature and title of certifier		29c License number	20d D	ata signed (Month, Day Your)			

6001 Muncaster Mill Road, Rockville, Maryland 20855

3. Time of Death

10:59

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

1 Yes 2 X No

Country India

14. Race - American Indian.

Specify: Asian-Indian

Black, White, etc.

January 31, 2010

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diane Ruckert CRNP,

re Quelet CRNP R115108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 20a, perFH, G900. 2/3/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 **Physician** Yea 1235 01 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Bon Secour Hospital Baltimore N/A5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Director 218-46-6287 62 04/10/1947 Pennšylvania Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examinar must be notified at Director 1 XYes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a Funeral 2585 W. Baltimore Street 21223 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify: Black ģ Specify. 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed withir Health and Mental Hygiene. College (1-4or 5+) 12th Grade Clerical Nursing Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should I Eli Kitchen ည Geraldine Tavares 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any Injury or other trau Karen Hill(Daughter) 8300 Flintloch Ct., Severn, MD 21144 20b. Place of Disposition (Name of Joseph Brown F/H And Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlat 2 X Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Baltimore, MD 21. Signature Funeral Service Licensee Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Luncer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Certification: To 1 ☐ Yes npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of of or Attending Patter death. 28c. Injury at Work? After 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only Medi one) 29b. Signature and t 29c. License number certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Baltimore 2000 210 31. Date filed (Man State Registrar

Physician /Medical Examiner

attending physician and for use as the burial-tran

signed by the a d be detached for

page 2

funeral

filled in by

certificate

i Director; Aid in by the fu

To the Hospital or Attending Physician:

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

^

Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Certification:

Medical

death with the Maryland

24a. Was an autopsy perform 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

determined

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Yes 2 🗌 No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D-20274

29d. Date signed (Month, Day, Year) Jan. 31, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7710 Bradley Blvd., Bethesda, MD 20817 Kirti Vohra, M.D.

Registrar

31. Date filed (Month, Day, Year) 32. Registar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -Month PM :05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Hospita Himoge altimore Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗆 🐔 Hours Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits by Funeral Director 1 Yes 2 No timore Street and Numb 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working /Seconday (0-12) DO NOT use retired) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ٩ 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship (Type, Print) or Rural Boute Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other od of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State S rvic Licensee 21. Signatu any i 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final On at and Death Ph sician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): certificate has been signed by the attending physician and irrector, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 Yes PNo Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Tes 12 No Other: ြု Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Investigation after death the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the 8 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospita

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 100M 0 ID /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Md. Healther Kenan 8. Date of Birth (Month, Day, Dec. 31, **Funeral** Birthplace (State or Foreign
Country) Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryia Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 🐪 o Director Baltimore atonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21228 Koaa Jamaica Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No timore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DD NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ည Qa. Informant's Name/Relationship (Type. Print) 19b. Mailing Address Phyllis Joyce 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tun of Funeral Service Licensee 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronan years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? certificate 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes tal or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place eath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ,2 🔁 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hin 24 hours after death.

the Funeral Director: After thi

mpletely filled in by the funeral or 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V alee Dr. Filkridge, led. 21075 Mar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32.

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifle

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

62234

10605 Concord Street, #300, Kensington, Maryland 20895

29d. Date signed (Month, Day, Year)

February 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10a-f. per Th. 8901 3/16/10 TT

AMEND TIEM#1/perFH, G906, 8/5/2010, WS

Certificate of Death

Reg. No. 1 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mildred Keay В. TAN .45 pm 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brighton Gardens North Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🛣 F 87 101-14-9035 N.T 1922 Director Nov. 3, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10b. County Pinellas 10c. City, Town or Location 10a, State 10d. Inside City Limits Seminole FL_{MD} Director **Montgomery** North Bethesda 12€Yes V□No 10e. Street and Number 111 Fernwood Circle Unit C 10f. Zip Code The Cardens, 106 Condo 34647 10g. Citizen of What Country? 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12 Finances 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Koay John U. Blease Ethel C. Blease ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Weida / Daughter 7208 Matthew Mills Road, McLean, VA 22101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 01/28/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Ligensee Dorota Marshall W. Marsua PO Box 1431, Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final arabborasculan Disuass **Physician** disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Transion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 month Month Dav 5 ☐ Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertorm certificate 2 - No 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To rthis 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation To the trospinal within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print)

GARY E. KAFFEL 11119 Rockers Lefikk #316 Rockville Md 20852 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death John Thomas Kunstman January 31, 2010 8:44 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months December 20, 1962 Wisconsin 390-74-6277 47 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 402 Barnside Place United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Actuary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald W. Kunstman Mary S. Heuring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Kunstman / Wife 402 Barnside Place, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20c. Location - City or Town, State February 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee _22. Name and Address of Facility_

Physician/ Medical **Examiner**

permit. Page 1.
Department of Important: If it any injury or o

Physician/

Medical

10a. State

Director

Funeral

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Completed

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Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	Mysale and	M01305	300 Wes	st Montgomery Ave	enue, Rockvill	kville, in Le, Marylar	rd 20850–2805		
	23a. Part / Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do cause on each line.	not enter the mo	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between		
	Immediate Cause (Final disease or condition	Melanoma					Onset and Death		
	resulting in death)	Due to (or as a consequence	of):						
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	; of):						
cal Exa	that initiated events resulting in death) Last	Due to (or as a consequence	of):						
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Unknown 23c. If yes, outcome of pregnancy 23d. Date of de 23d. Date of de 3d.								
ted by Pr	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying	g cause given in Part I.			the cause of death?		
comple					24a. Was an autopsy performed?	prior to	topsy findings available completion of cause of		
ge	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)				
0	1 ☐ Yes 2 🗓 No	spital: 1 lnpatient 2 ER/C	Outpatient 3 🗆	DOA Other: 4 \(\sum \) Nursing H	lome 5 ☐ Residence	6 X Other (Spec	Hospice IPU		
licate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b.	28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury						
Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, facto	ory, office	28f. Location (Street a City or Town, Sta		ral Route Number,		
Medica	(Check 2 Medical Examine	ian: To the best of my knowledge r: On the basis of examination and/ Practioner: To the best of my know	or investigation, i	n my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner state		
	29b. Signature and title of certifier	<u> </u>	25	9c. License number	29d. E	ate signed (Monti	h, Day, Year)		

January 31, 2010

Maryland 20855

Registrar DHMH 17 Rev 7/2009

State

6001 Muncaster Mill Road, Rockville,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Diane Ruckert, CRNP

FEB 0 3 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, perFH, G900, 2/3/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2010 Bonnie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Balt Levindale more 8. Date of Birth 06/12/1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foleign Country) **Funeral** Days 220-24-3251 1 □ M 2**½**□ F 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD 1 ☐ Yes 2 V No BALTIMORE Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 8804 JOSHUA COURT USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes ANNO If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL PODIATRIST ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAX MERDLER EVA ဂ SEIDLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ARTHUR KAHAN/HUSBAND 8804 JOSHUA COURT, BALTIMORE. MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State BETH TFILOH CEM. 01/30/2010 BALTIMORE, MD 5 ☐ Other (Specify) Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Fungral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oronaru /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 | Yes 2 | N Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and completed cause of death (Item 23a) (Type, Print) West Belvedere Ave., Sayed 3 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:53 PM Nathaniel Lance 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, 8–19–1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1x M 2 □ F Hours Country) 215-40-3473 Director 94 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

In the 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1X Yes 2 No MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3631 Lyndale Avenue S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry na (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lance Saulters Daisey Holmes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ralto, MD 21213 19a. Informant's Name/Relationship (Type, Print) 3631 Lyndale Brenda Brooks-Fiance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State King Memorial Pk 2-6-2010 4 Donation 5 Other (Specify) Randallstown, MD 21. Signature of Fund Service 22. Name and Address of Facility March East F/H MD 21202 Ε North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician STRUCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MONTHS MUC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit TASTAS MONTHS that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖯 only one) Cer frying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of d 29c. License number 29d. Date signed (Month, Day, Year) 24339446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Ye ar **Physician** 06:40PM Lathe <u>Walter</u> wan 26 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ST Agnes Hospita Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 21, 1 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1927 Maryland 1 X M 2 □ F 219-20-5534 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medicial Examiner must be notified at Y Yes 2 □ No Maryland Directo Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21229 402 Hazlett Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore 12 Sanitation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Η. Lathe Jennie Ε. ပ injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 402 Hazlett Avenue, Baltimore, MD 21229 Nellie A. Lathe (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Grds |Marriottsville, MD 2/1/10 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia days /Medical Due to (or as a consequence of): Examiner obstructive pulmonary disease Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an s certificate has build irector, page 2 st 1 □Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -owe P20657 2010 Jan, 27, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 900 Caton Ave, Baltimore, MD 21229 MAHMOUD AL-DANDASHI. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G900, 2/19/2010, WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Harry James Marable ам 53 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center
Social Security Number 6. Sex Towson Balto 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X**M 2 □ F Months Davs Hours Min. Month, Day, Country) 1940 69 Director 218-36-546 MD Usual Residence of Decedent shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD na Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3529 Esther Place Funeral 21224 U S Α 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. : If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha City of Baltimore Crew Leader 9th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert Larry Marable, Sr Dora Elizabeth Patterson and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ella Marable-Sister 822 Street Balto, Port Ν. MD 20a. Method of Disposition 20b. Place of Disposition (Name of Mt .ce Carome late Ceneters) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 2/17/2010 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify **Trinity** Cemetery -8-2010 Balto, MD 21. Signature of Fun ral Service March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician gastric disease or condition cance Medical resulting in death) Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🕅 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate I ☐ Yes 2 ☐ No 2 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 DO Other (Specify) NOSPLY ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accider work? injury 5 Pending 2 🗌 No Accident Investigation Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 🗌 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signat and title of certifie 29d. Date signed (Month, Day, Year) 2010 esivari 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARVES 6701 Charles ST TONSON MO Registrar's Signature 32. State

DHMH 17 Rev 7/2009

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Gertrude R. Murter 01-30-2010 530 A 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death 49 Crystal Ct Bel Air Harford | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 08-16-1935 Social Security Number 6 Sex 7. Age (In yrs. last birthday) (State or Foreign 1 □ M 2 🕶 F 74 PA 187-28-6526 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49 Crystal Ct 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo 1 □Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Erb Helen Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Murter 3170 Charles St Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. 02-02-2010 Fallston, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST disease or condition resulting in death) CANCER O YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) I Yes 2 X No 9 Unknown 9 Unknown

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, I'm Many injury or other event,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and the burial-tran attending p signed by the a d be detached f certificate has birector, page 2 s Hospital or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this

Medical Certification: To

29b. Signature and title of cortifie

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Division of Vital Records, P.O. Box 68760,

in t	ALE: us decedent pregnant the past 12 months? Yes 2 No Unknown	23c. If yes, outcome of pregnative birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	ıl death 3 ☐ Ectop	ic pregnancy (specify)			23d. Date of delivery Month Day Year
à Faith.	Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given	in Part I.		use contribute to the cause of death?
						24a. Was an autopsy performed?	
25. Was	case referred to medical			2	6. Place of Deal	th (Check only one)	
	Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other:	4 Nursing Ho	ome 5 Residence	6 ☐Other (Specify)
27, Mani 1 D 2 D	ner of Death Natural 5 ☐ Pending Accident investigation		28b. Time of Injury M	28c. Injury a Work? 1 □ Ye	t s 2 □No	28d. Describe how inju	ury occurred
	Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)			

29c. License number

00058475

DRUARR

29d. Date signed (Month, Day, Year)

FEBRUARY 1 2010

State Registrar

31. Date filed (Month, Day, Year) 32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denve B. park

PHYSTUEAN

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# 20 b, per FH, G900, 2 / 16 / 2010, wS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 2:04 Janua Vo 2010 /Medical Facility Name (If not institution, give street and number) 4c. County of Death or Location of Death Examiner Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K Months Days Hours Min Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MΝ 1**X**Yes 2 □ No Director Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21212 Radnor USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TANO If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Klack 2 3 Widowed 4 □ Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

ALLS ASSICATE Elementary/Secondary (0-12) College (1-4or 5+) is marked other Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be avnor ပ Mailing Address (Street and Number or Rural Route Number, Department of Health a Important: If item 27 is any injury or other tra once. Health a 3808 Ronner Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 4 ☐ Dometion 5 ☐ Other (3 Removal from State 5 Other (Specify) erel Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MyocaRdia disease or condition resulting in death) /Medical as a consequence of) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760. attending physi for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Yea 5 Other (specify) P.O. detached 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Physician: The perform Vital 2 No 1 □ Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 KR/Outpatient 3 ☐ DOA 1 Inpatient of Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Aath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending death, investigation 1 ☐ Yes 2 □ No 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

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nend #17 per Fh g900 2/9/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Diwaliben Mangubhai Mistry 2010/61 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore guare Haspi Tal Center Kosedale Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. **Director** 214-47-5685 6/5/27 Indía Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exandrian content traumatic event, the Medical Exandrian contents. Director 1 ☐ Yes 2 X No Md Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? Funeral 14913 Pomquay Court 20878 India 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. <u>≨</u> 3 M Widowed 4 □ Divorced Indian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home <u>Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fakirbhai Miththalbhai Fakinbhai Mistry <u>Maniben Miththalbhai Mistry</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bpin M. Mistry 14913 Pomquay Court Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 2/3/10 Baltimore, 22. Name and Address of Facility Loudon Park Funeral Tome 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore. Maryland 23a. Part1. Enter the disease, or shock, or heart failure. List implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. Approximate Interval Between Onset and Death Pailur Immediate Cause (Final **Physician** Rena disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Physician: The law requires that the death certificate be executed o Ca Due to (or as a consequence of): Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) P.O. ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ficate has been si r, page 2 should t 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Month, Day, Year) Injury PM 1 ☐ Natural 5 Pending n 24 hours after death.

Ne Funeral Director: A
pletely filled in by the fu death. 2 No 2 Accident investigation 1 TYes hile WALKING 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 2012mn 6600 Ridge Rd home Kosedale Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) 9000 31. Date filed (Month, Day, Year) emtor FEB 0 3 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:26 Mody A.K.A. Nellie White Mody 2010 White January Ne11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring
Under 1 Year | If Under 24 Hrs. Brooke Grove Rehab and Nursing Center Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Yrs. 88 Director 577**-**84**-**3817 March 8, 1921 England Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene. 27 is marked other than "natural", or liems 23a or 28a-4 shov traumatic event, Ins Meskerl Exproject must be notified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 8611 Hidden Hill Lane 20854 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Nicholas White Eleanor Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 15 Rice Street, Newton Massachusetts, 02459 Elinor Mody/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. February 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1, 2010 Bethesda, Maryland Cremătorium, Inc. 21. Signatur of Funeral Service Liven e Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. House M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Days Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Months Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached it 1 ☐ Yes 2 🔀 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Atrial Fibrillation, Hypertension, Hyperthyroid, Completed 24b. Were autopsy findings available prior to completion of cause of death? Colitis, Schizophrenia 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 No Attending Physician: After this certific funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A / filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifier

Anuradha Arun,

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10301 Georgia Avenue, Silver Spring, Maryland 20902 32. Registrar's

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0057630

29d, Date signed (Month, Day, Year)

January 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Co State of Maryland / Department of Health and Ment	
1 - For State Registrar Certificate of Death	Reg. No. 2111 12797
M	te of Death 3. Time of Death onth Day Year
Medical VIOla Nolah Feb	many of 2010 1308 PM
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center Baltimore	4c. County of Death
	tte of Birth 9. Birthplace (State or Foreign Country)
120 10 1203	te of Birth onth, Day, Year) -28-1933 9. Birthplace (State or Foreign Country) MS
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Howard Fulton	1 ∐ Yes 2 LMNo
g 70 loe. Street and Number 10f. Zip Code	10g. Citizen of What Country?
MD Howard Fulton 10e. Street and Number 11369 Liberty Street 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Never Married 2 Married 2 Never	USA
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican) 1 Never Married 1 Never Married 1 Yes 2 Yes 1 Ye	es or No- etc.) 14. Race - American Indian, Black, White, etc.
Thever married 2 married 1 Fyes, Give Year or Dates: 1	Specify: Black
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+)	Memphis Regional Medical Center
Note that the state of the stat	, Middle, Maiden Surname)
Tr. Father's Name (First, Middle, Last) Winfred Roberts Julia Ho	ui
기 등 등 등 기 19a. Informant's Name/Relationship (<i>Type. Print</i>) 19b. Mailing Address (<i>Street and Number or Rural Rou</i>	te Number, City or Town, State, Zip Code)
Kenneth Nolan-Son 11369 Liberty Street	
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2 National Cemetery 2-11-	20c. Location - City or Town, State
1X Burial 2 Cremation 3 Removal from State National Cemetery 2-11- 1 Signature of Fundral Service Licensee 22. Name and Address of Facility Mar	10 Memphis, TN ch F/H East
21. Signature of Fundal Service Licensee 22. Name and Address of Facility Mar 1101 E. North Av	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responds, or heart failure. List only one cause on each line.	iratory arrest, Approximate Interval Between
Physician Immediate Cause (Final disease or condition	Onset and Death 2 days
/Medical resulting in death) Due to (or as a consequence of):	7
Sequentially list conditions b.	
Tesulting in death) Last Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events	
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្នុំ ខ្លួន នៃ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
Completed by Compl	
a le law of the law of	4a. Was an autopsy findings available autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 1 25. Was case referred to medical 26. Place of Death (Che	yes 2 No 1 Yes 2 No
examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 9	☐ Residence 6 Other (Specify)
Set of Death (Che examiner?) 1	Pescribe how injury occurred
1 Matural 5 Pending (Month, Day, Year) Injury Work? 1 Matural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined determined determined wildling at (Specific)	
28a. Date of Injury - 28b. Time of Specify) 28b. Time of Injury at Work? 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ No 1 \ Yes 2 \ Yes Injury at Work?	ocation (Street and Number or Rural Route Number, ity or Town, State)
	ue to the cause(s) and manner as stated.
29a. Certifier (Check only one) 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29c. License number 29b. Signature and title of certifier 29c. License number	
5 5 5 6 1 W 1	29d. Date signed (Month, Day, Year)
29c. License number	T 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number	February 01, 2010
29b. Signature and title of certifier 29c. License number Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Howard MD 4940 Eastern Avenue Baltim	February 01, 2010 ore, MD 21224
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	February 01, 2010 ore, MD 21224

Amend #5, per Fif G900 2/12/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01-27-2010 9:40P Audrey A. Norrod Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3844 York Drive Havre de GRace Harford Social Security Number 212-45-7550 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Birthpiac DE 1 □ M 2 🕶 F 69 Months Days Hours Min. 0 #29 Day 940 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified. Harford 1 Yes 2 No Havre De Grace 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3844 York Drive 21078 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Madey Lucy Wojcik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forrest Norrod Jr. (Husband) 3844 York Dr Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Cemetery 02-08-2010 Arlington, VA 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Glioblastoma Multiforme Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by osteonyelitis of Lumbar Spine 1 Yes No 3 Probably 4 Unknown Decuinities where of sacrum 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No Hypertension 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 2- No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thuble no 1/29/10 0000 48050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 15 S. Parke Street Prashant Shakla mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Benen S. Jan

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND_ITEM#20b.perFH,G900,2/16/2010,WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 12115P M Month Day **Physician** George G. Neville, Sr. 31 lanuar /Medical Location of Death County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town Examiner YEDIC AC 1 IVISTA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☑ M 2 ☐ F 89 Yrs 579-12-5577 Director March 15, 1920 New Jersey Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Evaminer must be rutified at 1 X Yes 2 No Maryland Director Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 910 Neal Drive United States 20850 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Eventuranonce. 1 XYes 2 ☐ No If Yes. Give 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: à 3 Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gas Company 11 Plant Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet C. Torzewski George Alexander Neville ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Neal Drive, Rockville, Maryland 20850 Evelyn L. Neville/Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mary Land Veterans
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Cheltenham, Maryland 4 Donation 5 Dother (Specify) Pumphrey Funeral Home/ 22 Name and Address of Facility Robert A. Rockville, Inc. 1300 West Rockville, Maryland 2085 21. Signature of Funeral Service Licenses M01498 19 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 04 SIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit NOUNI Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, btota GASTROINTESTINA (bleed Physician/Medical DIECTOH TOR the attending photostal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? After this certificate h funeral director, page Chronic Obstructue 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident Injury 1 □Yes 2 □No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number D0026263 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) IVINGSTON Rd. Kleiman amuel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 3 201 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February1, 2010 Physician/ 9:05P. M Irene Pfarr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Brightview Asst. Living of BelAir BelAir 8. Date of Birth Month, Day, Year, April 29,1920 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours Mary Land Director 89 219-01-4365 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f slother traumatic event, the Medical Examiner must be notified a BelAir Harford Md. 1 Yes 2X No 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Completed by Funeral with USA 21014 Apt. 332 300 W. Ring Factory Road permit. Page 1 and 2 should be filed within 72 hours after death \times Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company 12th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Margaret Klein John L. Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Robin Lynne Ct. Perry Hall, Md. 21128 19a. Informant's Name/Relationship (Type, Print) 9 Robin Lynne Ct. DTR Jeanne Capobianco 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-6-2010 Baltimore, Md. Bayview 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licenses Shoumen Cosgnove 9705 Belair Rd Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or all a consequence of) **Examiner** Sequentially list conditions, Examine in any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specific 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29a. Certifier

only one

29b. Signature and title of certific

Hill 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

Corperale

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cause Trive

29d. Date signed (Month, Day, Year)

0

M. 21009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last. 2. Date of Death Physician Year 11:29 PM orman January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice-Northwest Hospital Pandallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220.12.9795 Months 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Director MD 1 ☐ Yes 2 No Raltimone. GNUNN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 01201 St. ane Lukes Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Deceded to 1 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ihe Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be M.C. Phillips Hollaway Edna Mae ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 St. Lukes Lane Grynn Dak, MD 21207 Edna S. Phillips 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison Forest Owings Mills, MD 09 10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaugan C. Green Funeral SVCS 22. Name and Address of Facility Dandallstown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration /Medical Due to or as a consequence of): Examiner aithems Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed sician and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed be Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law autopsy performed 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 🗌 No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI 1 C-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) DOUS3337 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Secry te 203 Baltimore, Mdzizua 2835 Smith Avenue

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02802 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Alfred Perschy 30, 2010 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10718 East Crestview Lane Laure Howard 5. Social Security Numb 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F (Month, Day, Year, ec 12.1 Months Min. Washington. Hours Director 577-50-0572 73 Ĩ′936 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10718 East Crestview Lane 20723 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 🗌 Widowed 4 🗆 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electrical Engineer Applied Physics Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of is marked of မ Perschy Francis Alice Reichenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is 10718 East Crestview Lane Laurel, Maryland 20723 Mary Kelly Perschy/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 2/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21, Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD M00957 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ M-21972MA Metastate disease or condition 7 8003 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami ending physician and use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Contact et time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ò Year Month Dav signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed Yes 2 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 ZINO ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 2 Accident work? 1 🗌 Yes 2 🗌 No 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun Investigation M 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MD 038409 completed cause of death (Item 23a) (Type, Print) 30. Name and address of p Limeralle, Ad, 21093 Rd Shartman 10123 F9 1/5 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per Fh G900 2/23/10 TT

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6:31 AM Lewis A. Ransom 02 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Center Baltimore Kosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ∏ M 2 □ F Months Days 215-42-5940 Director 66 June 3,1943 Maryland Usual Residence of Decedent death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Defice Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes X No Md. Balto. Nottingham 10e. Street and Number 10g. Citizen of What Country? 9 Bridle Lane 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2K Married 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Baltimore Co. Police Dept Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis F. Ransom ပ Olive Doreas Rily 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Bridle Lane Nottingham, Md. 21236 Linda A. Ransom Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-5-2010 Gardens of Faith Balto. Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastratic Prostate **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Day to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No page 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Matural 5 | Pending filled in by the f 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES 00000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lov Baltimore MD 21237 9000 Franklin Square Ginny French DR. MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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ORIGINAL

32. Registrar's Signature

10-00750 James Robertson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 02804 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.									
Physici	ian/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of								3. Time of Death		
Medical Exami	iner	James	Roberts	son				Month January 2:	Day Year 5, 2010	1938 hrs	
		4a. Facility Name (if not institution	n, give street and nu	ımber)	4	b. City, Town, or L	ocation of De		4c. County of	f Death	
		Anne Arundel Medica	Center			Annapolis			Anne Arundel		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes					If Under 24h	Irs. 8. Date of Bir	th(MM/DD/YYYY)	Birthplace (State or	
Director		217-48-8786	1 X M 2 F	50	Yrs.	Months Days	Hours M	Aug. 7	. 1959	Foreign Country) MD	
***		Usual Residence of Decedent	162 111		113.	<u> </u>			,		
È		10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits	
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4aryland 28a-f show any 1.at once.	ţ	40-04-4				101 71 0					
Mar.	Director	10e. Street and Number	71700110			10f. Zip Code	1234	110	Og. Citizen of Wha		
5-0036 led within 72 hours after death with the Maryland thygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at ones.	Ö	7510 Moye	Avenue			21	1234		US	A	
n wit	Funeral	11. Marital Status	A	edent Ever in U.		Decedent of Hispa s, specify Cuban,		Specify Yes or No-	14. Race - White,	American Indian, Black,	
deatl or ite	Ë	1 Never Married 2 M	arried 1 Yes	2 X No	,,,,,	s, specify Cuban,	Mexican, Fue	no Rican, etc.)			
after al",	by F	3 Widowed 4 XDiv	orced If Yes, Give Yea or Dates:	ır	1	Yes 2 X No	specify:		Specify:	White	
ours	ğ	15. Decedent's Education (Spe	cify only highest grad	de completed)		s Usual Occupatio st of working life. [16b. Kind of Bus	iness/Industry	
72 h	ompleted	Elementary/Secondary (0-12)	College (1	-4 or 5+)	_	soline Me		•	11+47	ities	
O3	합	12	1		Ga.	SOTTILE FIE	CHAILC		0011	10162	
S-0-5-0	ပိ	17. Father's Name (First, Middle,	Last)			18		me (First, Middle, M			
21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Robe	ertson				Els	sie Ell	iott		
21 ould d Me	မ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (Street	and Number o	or Rural Route Num	ber, City or Town	, State, Zip Code)	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Deanna Rose I	Robertson/	Daughte	r 4 A C	avalcade	Ct. E	Baltimore	, MD 212	34	
Ore, IN of Health If item 2		20a. Method of Disposition				ion (Name of ceme	etery,	Date	20c. Location - (City or Town, State	
Baltimore, permit. Pages I as Department of Hee Important: If ite		1 Burial 2 XCremation		om otate	crematory or other	•	. 1/	28/2010	Woodbi	ne.MD	
Baltimo permit. Pag Department Important: injury or ot		4 Donation 5 Other St. 21. Signature of Funeral Service		F1		mey Cren				110, 120	
Balti permit. Departm Imports		1 1 10. 1	11.0 . 1	. 17	- 1			tion Ser			
Physician	-	23a. Part I. Enter the disease, or	complications that c	aused the death	Do not enter the	PO Box 1	413. F	Baltimore	MD 212	03 rt Approximate Interval	
/Medical		failure. List only one cause	on each line.				uci i as cardiac	or respiratory arre	sst, sillock, of fleat	Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)		panol in		lon				Death	
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	ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	n·						
	١ <u>Ě</u>	cause. Enter Underlying Cause	С.		,						
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ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath. Total this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit			d								
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687 ertific ling	an/	23b. Was decedent pregnant in the past 12 months?	Live b	irth		Il death 3	Ectopic preg	nancy	Month	Day Year	
Box 68 e death certif the attending	sici	1 Yes 2 No 9 Unk	2011	ant at time of de	ath 5 Oth	er (Specify)				ŀ	
cords, P.O. Box 68 law requires that the death certif has been signed by the attending 2 should be detached for use as	څ		9 Onkno								
P.O.	by	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the un	derlying cause giv	ren in Part I.			ute to the cause of death?	
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eco ne law te has ge 2 s	ĔΙ							perfor	m <u>ed</u> ? de	ath?	
tal Reisian: The certificate									Yes 2 No		
Vital Rec ysician: The his certificate director, page	a	examiner?	Hospital:	npatient 2 🗸	EP/Outpatient		M		Residence 6	Other:	
Physi Physi er this	유	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of Ini				ow injury occurred		
n of \india of high high high high high high high hig	Ë	1 Natural 5 Pend	(Month	Day,Year)		1 Ve	s 2X No	unk	ow injury occurred	1	
Sior Attend death ctor:	[ä		tigation FC I		Fd 6:50	pm					
24a. Was an autopsy performed? 1 Ves 2 No 1 25. Was case referred to medical examiner? 1 Ves 2 No 1 25. Was case referred to medical examiner? 1 No Natural 5 Pending Investigation 2 No No No No No No No No No No No No No								ate) Champs	s House		
spita hours nera / fille	3 > 298 Centiler								County, MD		
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in											
Division To the Hospital or Attention 24 hours after dea within 24 hours after dear To the Funeral Directo completely filled in by the	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day										
		tota ()	- Toll	1_		O.C.M.	.É.		January 26,	2010	
<i>i</i> .	-	30. Name and address of person	who completed caus	e of death (Item	23a)						
10 1	1	Patricia Aronica-Pollak	MD. Assista	ınt Medical E	xaminer	111 Penn Stre	et, Baltimo	ore, MD 21201		1	
	ate	31. Date filed (Month, Day, Year)	010 32 Re	gistrar's Signatu	e			-			
Regist	rar		010 Cen	wa p	gar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 27, 2010 2:55 AM Physician TANUARY EVELYN RUSUELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOUPITAL BAITURE, MARYLAND MAP-BOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F Yrs. 65 Jan. 9, Maryland 1945 Director 217-40-8619 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show traumatic event. The Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Lansdowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If flem 27 is marked other than "natural" any injury or other traumatic average. USA 2110 Alletta Avenue 21227 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ∐Yes 2 ☐ No If Yes, Give ^X Year or Dates: 1 Never Married 2 Married Specify:White 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sherwin Williams Paint Technologist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Rodgers John Lewis Weedon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2110 Alletta Ave., Lansdowne, MD 21227 Robert M. Russell (Husband) 20b. Place of Disposition (Name of Baltimore Crematory) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 2/1/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) @ Loudon Park 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEMIC Physician PAYS MOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): MONTHI **Examiner** CANCER TO BIMES, WITH METATANO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) AMENOPATHY or Attending Physician: The law requires that the death certificate be executed DAY PANCY POPENIA for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown HYPERTENION 24b. Were autopsy findings available prior to completion of cause of death? PHENMADIO 24a Was an autopsy performe of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Dipatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division 1 Natural 5 Pending ours after death.

neral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

CHERRIE PERIMUIO 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MORPITAL. 3001 South Hanover Sheet, Baltimor, MD 21225 MARBOR 32 Registrar's Signature

PRY 1, INTERNAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICINE

29c. License number

Ret

0001

29d. Date signed (Month, Day, Year)

JANUARY 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month 30,2010 1450P January William D. Rassa, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Air 1 Year | If Under 24 Hrs. | Min. <u>Harford</u> Upper Chesapeake Medical Center Bel 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Months 1**½** M 2□ F 89 6-22-1920 MD 218-07-7267 10c. City, Town or Location 10d. Inside City Limits 10a. State Harford 1 Yes 2 □ No Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1812 Philadelphia Road 21085 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 XYes 2 No
If Yes, Give
Year or Dates: WW I I 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Railroad Worker Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph A. Rassa Anna Holdorf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Rassa - Son 1812 Philadelphia Rd., Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 2-2-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Euneral Service Licensee 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ugestino Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year

Physician /Medical **Examiner**

Department of Heal Important: If item 2 any injury or other once.

Pages 1

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show ofcel Examiner must be notified at

event, the Medical

Baltimore, Maryland 2121

P.0.

Funeral Director

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Completed

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Examiner

Physician/Medical

Completed

Be

Medical Certification: To

page 2 s

Hospital or Attending

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

MD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown

5 Other (specify)

Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	1 ☐ Yes 2 ☐	MQ
	24a. Was an autopsy performed? 1 □ Yes 2 □ Wo	24t
26. Place of Death (0	Check only one)	

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner? 1 Tes 2 No 27. Mann of Death

29b. Signature and title of certifier

Watural

2 Accident

3 Suicide

4 ☐ Homicide

1 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

6 ☐ Could not be

determined

2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year)

Haure de Grace

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 02807 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:30 рм Eva Mae Sherman 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Athol Balto If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X XF Days Hours 85 Director N.C. 237-22-7388 Usual Residence of Decedent show 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No Balto MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 839 Round Road 21225 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CXNo Specify. Specify: Black 3 → Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H is marked of permit. Page 1 and 2 should be filk Department of Health and Mental Important, If item 27 is marked of any injury or other traumatic eve ည William Beckwith Pearl Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) apt 423 Daughter Jeanette McFarlane 1705 E. Eager Street Balto, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ouantico National 2-9-2010 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funda Service Live 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final ARTERY DISEASE Physician/ CURENARY disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Month Day Year 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by FAILURE TO THRIVE 1 Yes 2 No 3 Probably 4 Unknown Completed DECUBITUS ULCER, RESPIRATORY FALL AND 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 📉 No ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Medical

State Registrar

29b. Signature and title of qe

rtifier

MATEEN AWAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

10802 HICKORY RIDGE RD COLUMBIA Registrar's Signatur

1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Doc 62634

29d. Date signed (Month. Day. Year) JANUARY 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0.2010 Month Madeline N. Schmidt January 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Middle River HMOHE Ivy Hall If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 082-07-0522 1 □ M 2 👿 F 97 191 pril Usual Residence of Decedent 10c. City, Town or Location Baltimore Nottingham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 30 Bartley Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Castillaneta Paolo Tateo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 30 Bartley Court Nottingham, Md. 21236 Roberta C. Marques 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2-2-2010 Balto. Md. Bayview Signatur of Funeral Service Inc. 22. Name and Address of Facility Schimunek Funeral Home Nottingham,, Md. 21236 9705 Belair Rd. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician Medical **Examiner**

Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the Monce.

Physician/

Medical

10a. State

Md.

Funeral Director

Completed by

Be

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Examiner

Funeral

Director

or 28a-f

ms 23a or must be r

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

use for within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

9 3	Immediate Cause (Final disease or condition	De me ntia		Onset and Death		
	resulting in death)	Due to (or as a consequence of):				
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or limitary	Due to (or as a consequence of):				
ical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1	23d. Date of de Month	livery Day Year		
leted by Pł	Part II. Other significant conditions conf	tributing to death but not resulting in the underlying cause given in Part I.		the cause of death? robably 4 Unknown		
Comp			autopsy prior to performed? performed?	completion of cause of		
	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	26. Place of Death (Check of Depthal) population 1	only one) e 5 ☐ Residence 6 ☐ Other (Spec	cify)		
icate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? M 1 \[\text{Yes} 2 \text{ No} \] No				
l Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certificate: To	(Check 2 Medical Examine	inan: To the best of my knowledge, death occured at the time, date and place, and in the basis of examination and/or investigation, in my opinion, death occurred at the Practioner: To the best of my knowledge, death occurred at the time, date and place,	ne time, date and place, and due to the	cause(s) and manner state		

29c. License number

D61907

29d. Date signed (Month, Day, Year)

Avenue Bustimore MD 21221

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

hukwuma 31. Date filed (Month, Day, Year)

ruks Uso

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1124 Mace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #4a, permE e900 2/3/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 13:08 PM 01 27 2010 Earl William Soth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ·Cilchrist Center Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**X**M 2□F 07/19/1916 Director Maryland 219-01-0232 93 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 X No Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 7 must be n U.S.A. 9025 Carlisle Avenue 21236 Completed by Funeral 14. Race - American Indian, ral", or items 2 Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than "nature went, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. Truck Driver 7 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 2 should be fi Elizabeth Gerst P Christian Soth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 9025 Carlisle Avenue - Baltimore, Maryland 2 e of Disposition (Name of Date 20c. Location - City or Town, State 21236 Ruth Ann Bachelor (daughter) permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns.01/29/2010 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses 6 X Jassahns 11750 BelairRoad - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Harma SWIN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death signed by the a P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ No 24a. Was an autopsy pertormo 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Trong 20, 2010 1530 P M 1 1 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Division 1 Natural 5 ☐ Pending investigation Burned in house time 1 ☐ Yes 2 💢 No Accident spital or Attendliours after death.
neral Director: A death. 28f. Location (Street and Number or Flural Floute Number, City or Town, State) 90 25 Ga - 1/5/6 Aug Perry, HGII MD 21360 6 Could not be determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item (3a) (Type, Print) 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

tobert Starcher		State of Maryland / Department of H 1-For State		Reg. No.	10 0201
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date	of Death	3. Time of Death
Medical Exami	ner	RODELL 1. Starther		uary 31, 2010	1029 hrs
			City, Town, or Location of Death Baltimore	4c. County of De.	auri
Funeral			f Under 1 Year If Under 24Hrs. 8. Date	te of Birth(MM/DD/YYYY) 9. I	Birthplace (State or
Director		213-24-5790 1XM 2 F 80 Yrs.	Months Days Hours Min.	6/17/1929	country)Virginia
'n		Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location			10d. Inside City Limits
iow any					1 Yes 2 No
Aaryland 28a-f show 1 at once.	g	MD Baltimore Glen Arm 10e. Street and Number 10	Of. Zip Code	10g. Citizen of What Co	ountry?
the M	ă	11752 Camp Cone Road	21057	U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? (Specify Yespecify Cuban, Mexican, Puerto Rican, e		erican Indian, Black,
er deal		1Yes 2 X No	s 2X No specify:	Specify: Whi	ite
urs aft tural'	à P	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's United Section 15. Decedent 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent's United Section 16a. Decedent 16a.	Jsual Occupation (Give kind of work don		
6 72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use retired)		
withir grene.	mo.	12 2 Salumon S	esman 18. Mother's Name (First, M	Tractor	Company
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be C	Leland B. Starcher	Winna Phil		
213 ould b d Men s marl	2		Idress (Street and Number or Rural Ro		ate, Zip Code)
MD and 2 show alth and m 27 is aumatic		June C. Starcher (wife) 11752 (20a Method of Disposition 20b. Place of Disposition	Camp Cone Road – G	len Arm, Mary	and 21057
Ore, es l ar of Her If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other	place)		
altimore, mit. Pages I ar partment of Hee programt: If ite		4 Donation 5 Other Specify: Moreland Mel	morial Pk. $02/04/2$ e and Address of Facility $E. F.$	2010 Baltimore	e, Maryland
Balti permit. Departr Import injury			0 Belair Road - Ki		
Physician	\neg	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n failure. List only one cause on each line.	node of dying, such as cardiac or respira	atory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	se		Death
		b			
	<u>le</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
.=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ecuted and trans	삙	d			
60, tie be executed hysician and e burial - transit	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d, Date of deliv	erv
5876 ertifical ling ph	an/N	23b. Was decedent pregnant in the 1 Live birth 2 Fetal of	death 3 Ectopic pregnancy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/N		(Specify)		
that the d		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I. 23	e. Did tobacco use contribute	to the cause of death?
F. P.C ires that signed I be deti	d by			Yes 2 No 3 P	
ords, F aw requires nas been sign 2 should be	Bet			autopsy prior t	autopsy findings available o completion of cause of
Rec The la icate h	Completed			performed? death Yes 2 No 1	
Division of Vital Records, P.O. rial or Attending Physician: The law requires that the stater death at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26.Place of Death (Check only one DOA Other4 Nursing Home		ner.
of V g Phys fter thi	밁	1 V Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		escribe how injury occurred	
ion tendin eath or: A	햝	1 Natural 5 Pending 2 Accident Investigation (Month, Day Year)	1 Yes 2 No		
ivisi or At after d Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa		cation (Street and Number or Town, State)	Rural Route Number, City
Ospital hours uneral	ပိ	4 Homicide determined (Specify) 29a Certifier 1 Certifying Physician: To the best of my knowledge death occurred	et the time, date and elega and due to t	the cause(s) and manner as s	totod
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated			
F 8 5 8	B	29b. Signature and title of certifier	29c. License number	29d Date signed (/	Month, Day, Year)
		and	O.C.M.E.	February 1, 20	10
		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	eet, Baltimore, MD 21201		
St	ate	0.00	- s, seasons of the Erect		
Regist					
DHMH 17 Rev 1/2	001	OCME ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN. CAMERON CROCKETT SNYDER 2010 3:15PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5163 Terrace Drive Baltimore County Baltimore 8. Date of Birth (Month, Day, Year) Oct. 9.1916 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1**X**XM 2 □ F Months W - VA 212~16~8271 93 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Baltimore Baltimore County 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21236 5163 Terrace Drive USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1941~43 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 12 yrs. College (1-4 or 5+) 4 yrs. Baltimore Sun Sportswriter permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelvn M. Crockett Burwell C. Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5163 Terrace Drive Baltimore, Md. 21236 Frances Snyder (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XXX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2~2~2010 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemeterv Baltimore, Md. of Funeral Service Licenses ในระสักด์ คับที่อีรีฟ้า Home 7401 Belair Rd. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Caveinom disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of): Examir and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 the attending phone that the standard the st IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home ည 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 Yes 2 No injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar MD.

Day, Year)

705 O1917 A Dr. Cinstiian, Mary L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John L. Vogel binuary 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner edale If Under 24 Hrs. center timore Sex 1 M 2 □ F Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Davs Hours 213-44-9659 Director 66 16,1943 Maryland October | Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show 1**X** Yes 2 □ No iral", or items 23a or 28a-f sh Examirer must be notified Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4113 Balfern Avenue 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 🌠 No \$ Specify. Specify. White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Motor Repair Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John A. Vogel Frances Schmith ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Vogel Son 1302 Gill Street Odenton, Md. 21113 Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 0aklawn 2-3-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Slage **Physician** disease or condition resulting in death) /Medical Due to (or as a consuluence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a considuence of attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) detached Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page certificate 2 No 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manper of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Iniury investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be after death. Director: Af

Satimore, Maryland 21215-0036

the

3 ☐ Suicide

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Hou 24 hours a 29a/. Certifier 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check or 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 29b. Signature and title of certifie 29c. License number DO060560 30. Mame and address of person who co pleted cause of death (Item 23a) (Type, Print)

3

DENTHA BO # 200, BALTIMORE, MO 0106,0 TURA Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20b, perFH, G900, 2/9/2010, WS
State of Maryland / Department of Realth and Mental Hygiene Certificate of Death 1. Deceden's Name (First, Middle, Last) 2. Date of Death **Physician** nhe nes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 312 Lawnwood Circle Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03 13 1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 X F Months 216.40.0748 Days Director Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Messel Examiliant must be need for any injury or other traumatic event, the Messel Examiliant must be need for any injury or other traumatic event, the Messel Examiliant must be needed. Baltimore Baltimore MD 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2312 Lawnwood 21207 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 9 Specify: 1210 CK. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Administrative) ssistant 17. Father's Narke (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorse Marie Hammond ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stone Cliff Drive #305 Baltimore MD 20c. Location - City or Town, State 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 09^{ate} 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Windsor Mill, MD King Memorial Park 21. Signature of Funeral Service Licens

Vauxon C. J 22. Name and Address of Facility VIII TIN C. Greene Functof services Road Randallstown MD 21133 8728 Liberty 23a. Part1. Enter (he) disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760 physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 100 9 Unknown Month Day Year 5 Other (specify) the 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was autopsy performer this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Certification: 28c. Injury at Work? After 1 1 Natural
2 Accident 5 Pending investigation A 1 ☐ Yes 2 ☐ No n 24 hours atter death.

The Funeral Director; A pletely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15 V 30. Name and address of person cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#23a, perPHYS, G900, 2/3/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** WOODS HARD 3:40 AM 13 anuary .2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death BALTI SECOURS BON HOSPITAL MORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Year) Months 1 **X**M 2 □ F 80 N. Carolina **Director** 06/12/1929 240-48-1533 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Exaction must be notified at Director 1 Yes 2 □ No N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2126 Streamway Court 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, If a In-othe once. Elementary/Secondary (0-12)
7th Grade College (1-4or 5+) N/A Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Woods Myrtle ဥ Paylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Saratoga Apt 309, Dorothy R. Woods (Wife) 751 Balto., MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place)

Joseph Brown F/H
And Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 01/15/10 | Baltimore, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee elliano 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Septicemia** Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner ACUTE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medica examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Atural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0030355 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOURS 05 31. Date filed (Month, Day, Year, 32. Registrar's Signatu State

Registrar

10-00932 Matthew Weinberg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

thew Weinbe	-	- For State	Stat	e of Maryla	nd / Depar <i>Cert</i>	tment of <i>ificate of</i>	Health and Death	d Menta	ıı rygiei	Reg.	No.	201	0	02815
Physicia		Registrar 1. Decedent's Name (ast)	1				2. Date Mor	e of Death hth Daruary 1, 2	ay	Year		of Death O hrs
al Examir	ner		thew		berg		4b. City, Town, or	Location of I		ruary 1, A		nty of Death	1	
	ı	4a. Facility Name (if n		give street and no	mber)		Rockville Montgomery							
Funeral Director		5. Social Security Nur 213–17–81	71	Sex	7. Age (In yrs. las) III III III IIII				8irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD			
a	ļ	Usual Residence of D	Decedent 0b. County		10c. City,	Town or Locat	ion						1	side City Limits
ow any		10a. State 10		tgomery			mantown							Yes 2 No
aryland 8a-f sh at onc	Director	10e. Street and Numb	ber				10f. Zip Code	7.4		10g.	Citizen o	f What Cou ΣΔ	intry?	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	11. Marital Status 1 X Never Married	d 2 Mari		cedent Ever in U.S orces? 2 X No	S. 13. Wa	es, specify Cuba	in, Mexican, F	Puerto Rican,	etc.)		White, etc.	White	
fter de l'', or	y Fu	3 Widowed	_	rced If Yes, Give Ye	ar	1	Yes 2 X No		and of work do	200 11	Spec 6b Kind o	of Business	/Industry	
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36 tin 72 h	Completed	Elementary/Secon	idary (0-12)	2	1-4 0(5+)		Student					llege		
5-00 led with Hygien other	Con	17. Father's Name (F	First, Middle, L	_ast)				18. Mother's	Name (First,	, Middle, Ma ane H	iden Surn [ende:	ame) rson		1
121 Id be fi Mental narked event,	o Be	19a. Informant's Nan				19b. Mailir	ng Address (Stre	eet and Numb	per or Rural F	Route Numb	er, City or	Town, Sta	te, Zip Co	ode)
MD 2 shouth and 1 27 is 1 umatic	-			g / Fath	er		Ward Kl		Date	ersvii	20c. Loca	tion - City o	or Town,	State
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 7 agreenent of Health and Mental Hygiene. portant: If item 27 is marked other than jury or other traumatic event, the Medical pury or other traumatic event,		20a. Method of Disp 1 8urial 2	osition Cremation	3 Removal	from State Fi	place of Dispo crematory or o nal Jo	other place) Surney Cr	emetery,	2/4/20	- 1		bine,		
timo t. Page tment rrtant: y or ot		4 Donation 5 21. Signature of Fur	Other Spe	ecify:			Name and Addre Marylar	Famility	nation	Sorvi	Ces			
Bal permi Depar Impo injur			0 i	1 11.0		.	DO D	1 1 1 2	Daltir	mara	MD 7	1203	Ann	roximate Interval
Physician		23a. Part I. Enter the failure. List only	e disease, or o	on each line.		. Do not enter	the mode of dyin	g, such as ca	ardiac or resp	iratory arres	st, S110CK,	Ji Hoare		ween Onset and Death
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ed	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							\bot					
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Box 68760 e death certificate in the attending physed for use as the b	Physician/Me	past 12 months	s?	4 Pre	gnant at time of death 5 Other (Specify)									
BOS e death the att	1 2	Part II. Other signi			nown	resulting in th	e underlying caus	se given in Pa	art I.	23e. Did to	bacco use	contribute	to the ca	ause of death?
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n of ading Pl th.			5 Pen	ding Feb	onth, Day, Year) I, 2010	1930 hrs	1	Yes 2	No No					arking garage
Division of Vital Records, talor or Attending Physician: The law requirers after death. To after death. To after the fine certificate has been since in his fine for a second or second.	Cortification: To Be	2 Accident 3 Suicide	6 Cou	ald not be	Place of Injury - At			ce building, e	l l	Location (S or Town, S 002 Somer	tate)			oute Number, City
id ion	Ball t				hest of my knowle	adae death o	courred at the time	e, date and p	lace, and due	to the caus	se(s) and r	manner as	stated.	
To the Ho within 24 To the Fu	completely	(Check only one) 2		Physician: To the aminer:On the ba and mann	sis of examination	and/or invest	igation, in my opi	nion, death o		e time, date	una piase	e, and due to		Jse(s)
or with	00	29b. Signature an	id title of certifi					cense numbe	r			uary 2, 2		Jay, rear)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month LaDona M. Wrightsman 3:47A Medical Japuary 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brightview Asst. Living of BelAir BelAir Harford . Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 6. Sex 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Days Ju My^{nth}26", 1939 MaryTand 220-34-1927 70 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Harford BelAir 10e. Street and Number 10g, Citizen of What Country? Funeral 504 E. Wheel Road USA 21015 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14, Race - American Indian, Black White etc. . or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", 3X Widowed 4 ☐ Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Inventory Control Clerk B&G&E Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Evelyn L. Mills Joseph M.Monnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Cindy Dietz BelAir, Md. 21015 504 E. Wheel Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2-4-2010 Cumberland, Md. 4 Donation 5 Other (Seecify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home hen <u>610 W. MacPhail Rd. BelAir, Md. 21014</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ brova disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, and I-transit Due to (or as a consequence of): resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes has been sig e 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Hospital: Other: 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 9114 Philadelphia ROAD BACTO.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Katherine Elizabeth Walter 20 l 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Deat 4c. County of Death 058 If Unde If Under 24 Hrs. 8. Date of Birth . Age (In yrs) last birthday Birthplace (State or Foreign Country)
 Maryland **Funeral** 1 □ M 2 👿 F Months Hours Min (Month, Day, Year) 0/18/1916 Director 215-09-5391 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 Yes 2 No Fairfax VA Annandale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral U.S.A. 9014 Windflower Lane 22003 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Homestead Flower Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper and 2 should be filed wit Health and Mental Hygie em 27 is marked other Gardens Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Venzke Anna Welzenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Walter (son) 9014 Windflower Lane - Annandale, Virginia 22003 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Michael Luth.Cem. 02/02/2010 Baltimore, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a conse e e of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 Yes Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work? after death. eral Director: A filled in by the fu 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State, within 24 hours a

To the Funeral C

completed filled edical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Cotherine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year FRANK J. WINTER, 2:40 AM 30,2010 anvar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Square Franklin Haspital Kosedale Saltimore Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 3,1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 214~18~9577 89 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director Maryland Baltimore Baltimore County 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Middoal Evan Last to be monee. 10g. Citizen of What Country? 6717 Kenwood Avenue 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1XX∷Yes 2⊡No IfYes, Give Year or Dates†WW 11 1 Never Married 2 Married altimore, Maryland 21215-0036 Š 1 □Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) Electric Co. 2 yrs. 12 yrs. Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Winter Marie Loukoto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8345 Analee Avenue Baltimore, Md. 21237 Frank J. Winter, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Church Cemetery | 2-2-2010 Baltimore, Md. re of Funeral Service Licensee 7401 Belair Rd. 22. Name and Address of Facility Lassahn Funeral Home Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) cano ung /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.0. ed by the a ☐Yes 2 No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been si ; page 2 should t Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐ No 1 □ Yes 2 No After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month; Day, -Year

Dinh

30. Name and address of person who co

Nguyen

guare Drive Baltimore.

NGUYEN, BINGH

impleted cause of death (Item 23a) (Type, Print)

9000 Franklin

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physician/ Jan. ams 2:10 PM 2010 Medical **Examiner** 4b. Citv. Town, or Location of Death 4c. County of Death ttospice more imonium 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Director show 10b. County 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location death with the Maryland **Funeral Director** 10d. Inside City Limits Yes 2 No timore 10f. Zip Code 10g. Citizen of What Country? Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be USA 5100 l Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🖬 No Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working life. I/O NOT use retired) 15. Decedent's Education 1. Williams (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) TOYA Be ther's Name (First, Michele, Maiden Surname) မ 5100 **Voudsi** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other anuary 1🔏 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) sarriso n Signature of Funeral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LIVER CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impory Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by JOSEPH 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 2 **X** No 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending Accident
Suicide
Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JONES, **CRNP** TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Redistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02820 Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ January 2010 Annie Mary Webb 16:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Hours 1 M 2 X F Dec. 15, 1923 Pennsylvania 86 Director 579-26-8061 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Gaithersburg Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Russell Ave., #224 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 ☐ Yes 2 🔀 No If Yes, Give 2 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Newberry Hughes Florence Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2224 Wintergarden Way, Olney, Virginia Webb Styer/Daughter Maryland 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 3, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 2010 Brentwood, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01548 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Physician, Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Rapid Uncontrolled Atrial Fibrillation 6 days Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Overwhelming Sepsis 2 days and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death the detached 9 Unknown P.O. þ signed I Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 X No 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

anty one

29b. Signature and title of certifier

(Dun

MD

Belay Woldegiorgis Atnafu, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0069759

5000 W. Chambers, Milwaukee, WI 53210

29d. Date signed (Month, Day, Year)

31/10.

29c. License number

Corrifying Nurse Prantice or To the Sest of my knowledge, digits accurate at the time, data and plans, and due to the cause(e) and manner as state.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			ForState	State of Ma	aryland	-	artment of H tificate of D		and Me	, ,	21	010	02821
			Registrar 1. Decedent's Name (First, Middle	e, Last)		007	imouto or E	Catin		2. Date of Dea		0 1 0	3. Time of Death
	Physicia Medic		Kathleen Lois	Zimmerman			Month January				31,20	Year 10	1:05P ^M
	Examin		4a. Facility Name (if not institution	, give street and number)			4b. City, Town, or	Location	of Death		4c. Cour	nty of Death	
	F		Gilchrist Hosp 5. Social Security Number	st birthday)	Towson If Under 1 Year	If Under	r 24 Hrs.	3. Date of Birth		Balto	place (State or Foreign		
	Funeral Director		216-44-1905	Yrs.	Months Days	Hours	Min.	(Month, Day,	Year)	Cour			
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ary	nould ind Me s mar umati		Robert W. Power 19a. Informant's Name/Relations			19b. Mailin	g Address (Street a					, State, Zip	Code)
Ž	1 and 2 should be filed. Health and Mental Hitem 27 is marked of other traumatic ever		Jeanne Powers	Sis	ter	388	5 Schroed	ler A	venue	Perry	Hall	, Md.2	21128
ore	e 1 ar t of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State		ace of Dispos emetery, crem	sition (Name of natory or other plac	e)	Da	te	20c. Locatio	n - City or To	own, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 🕏 ☐ Other (Specify)		ayview			2-2-		Balto.		
Ba	permi Depar Impo any ir		21. Signature of Funeral Service	Icensee		22	Name and Addres 9705		™Scni ir Rd		unera. ingha		
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89	eath certifica attending pl	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc				23d. I	Date of deliv	very
P.O. Box 687	death	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 XNo	4 Pregnant a			Other (specify)	у			1	Month	Day Year
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 🔲 Medical I	Physician: To the best of Examiner: On the basis of each Nurse Practioner: To the	xamination	and/or invest	igation, in my opinio	n, death o	occurred at th	e time, date an	d place, and	due to the ca	use(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifie				29c. License		, p		9d. Date sign	_	
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	120		30. Name and address of person	who completed cause of d	eath (Item	23a) (Type, P	rint)		(r	Tow son	1 ~		•
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier one) 29c. License number D0027055 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	,0928	icate be execu physician and the burial-trar	lical	that initiated events resulting in death) Last		of):							
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Description) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL H. WILKERSON, M.D., 204 MEDICAL CENTER ROAD, GRASONVILLE, MD 21638	vision of	r Attending Phy er death. rector: After thi	tification: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day, Year) 28b. 28b. Place of Injury - At home, f	Time of Injury M	28c. Injui Wor 1 □	y at k?	28d. Describe how 28f. Location (Stra	v injury oo	curred		ıber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL H. WILKERSON, M.D., 204 MEDICAL CENTER ROAD, GRASONVILLE, MD 21638	۵	Hospital o 24 hours aff Funeral Di stely filled ir		(Check only 2 Medical Example 12 Medical Example 2 Medical Example	nysician: To the best of my knowledgeniner: On the basis of examination a				e, and due to the ca	use(s) an			3)
JOEL H. WILKERSON, M.D., 204 MEDICAL CENTER ROAD, GRASONVILLE, MD 21638		To the To the Comple	Mec		Weller				29	,		ı, Day, Year)	
31 Date then they read 1 A Manistrat Substitute		Ms		JOEL H. WILKERSO	N, M.D., 204 MEDI	(Type, Print) CAL CEN	TER E	ROAD, GRA	SONVILLE,	MD	21638		

DHMH 17 Rev 1/2001

Registrar

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JAN 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **ELIZABETH** ARNETT **Physician** MARINA January 13,2010 \mathbf{A}^{M} 8:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 31 Eton Overlook Rockville Montgomery 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Social Security Number 479-03-4318 **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. August 15,1913 Iffinois 96 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Wedford Exam, in a to mother traumatic event, the Wedford Exam, in a to mother traumatic event, the Wedford Exam, in a to mother traumatic event, the Wedford Exam, in the Medical Exam, MD Montgomery Rockville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 31 Eton Overlook United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify. White ģ Specify: 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valere Neirinck Marina LaMont ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 41033, Bethesda, MD 20824 Bunnie Guardado (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State January 13, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Crematory Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral S Ce Li, e see DeVol Funeral Home M00689 10 East Deer Park Dr. Gaithersburg, MD 20877 23a Part Et 1: the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock ic hear failure. List only one cause on each line.

Immediates or condition resulting in death)

a. Approximate Interval Between Onset and Dea **Physician** m /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 icate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1月Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical YCheck only 29c. License number 29d, Date signed (Month, Day, Year) 29b. Shanature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JAN 15 2010

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira N. Brecher M.D.

D00428

2101 Medical Park Dr. #304 Silver Spring, MD 20902

January 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anderson Linda K. 0045 A 2010 Jan. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 M 2x 52 Director 578-78-9196 1-9-58 Wash DC Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD. Montgomery Germantown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 U.S.A. 13048 Open Hearth Way death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify:Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gracie Anderson Kenneth Earl McManus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11674 Mustang Creek Ct. Waldorf, Md. Kennetha Fobbs/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Heritage Mem. Cem 1/22/10 Waldorf, Md. Funeral Service License 21. Signatury Name and Address of Facility
Hackett's Funeral Chapel, Inc. W Upshur Street, N W 20011 Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u>30 min</u> Cardiac Arrhythmia Medical Due to (or as a consequence of) Examiner hour Respiratory Failure Sequentially list conditions ause. Enter Underlying Exami and I-transit that the death certificate be executed Cause (Disease or linjury day COPD Exacerbation that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes No Month Day Pregnant at time of death ned by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed i 23e. Did tobacco use contribute to the cause of death? <u>و</u> 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 NOA မ To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my or large, death and place and place. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year,

JAN 20

James McOuiston, M.D. 9901 Medical Center Dr. Rockville, Md 20850

ess of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

01/16/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02825 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month January 11, 2010 Elizabeth 3:22 a M Louise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heart Homes at Bay Ridge Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Nov. 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1917 1 □ M 2 🖾 F Country) 92 Yrs 578-18-3386 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10c, City. Town or Location 10d, Inside City Limits 10a. State 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 3023-A Arundel on the Bay Road 21403 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Ernest Swingle Alice Lee ဥ 21401 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (5) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Richard Ernest McBrien/Son 2004 Harbour Gates Drive, Apt. 85, Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Jan. 15 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 any 23a. Part 1. Ent., the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** advance leans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 mg Month Day 5 Other (specify) as been signed by the 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 □ No 1 ☐ Yes of Vital 2**12** No 1 □ Yes Be 25. Was case referred to medical Assisted 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) After this funeral dir 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident mpletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide e Funeral Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I within 2 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) 50725 terars Huy M. Wersulle, MD 21108 Name and address of person who completed cause of death (Item 23a) (Type, Print) 860 enni ter Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 15** Registrar

DHMH 17 Rev 1/2001

10-00685

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Damien Baruffi State of Maryland / Department of Health and Mental Hygiene 2010 02826 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHRISTOPHER BARUFFI Month DAMIAN **Medical Examiner** 1424 hrs January 23, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 4711 Coastal Hwy Ocean City Worcester **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 227-92-6861 Director Months Davs 39 Hours 1 X M 2 F April 5, 1970 Yrs Country) Virginia Usual Residence of Decedent 10b. County 10c City Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 28a-f show 1 Yes 2 X No other than "natural", or items 23a or 28a-f shothe Medical Examiner must be notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11801 Rockville Pike #704 20852 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married White etc. Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: <u>م</u> r Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Landscape Architect Landscaping 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Louis Baruffi Rosemary Haught Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ Lisa Baruffi (Wife) 11801 Rockville Pike #704 Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place)
Calvary Mem. Pk. 1 X Burial 2 Cremation 3 X Removal from State 27, Fairfax, VA 2010 Donation 5 Other Specify 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Alcohol intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical tending physician a use as the burial -X UNPENDED AMENDED 23a,27,28a-f,perm,E g900 2/24/10 TT Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ σ. 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural unk 5 Pending 1 Yes 2 X No Director: ţ Fd 1/23/10 Fd 2:24 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4711 Coastal Hwy Unit 485 Ocean City, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide residence within 24 hours a determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** O.C.M.E. January 24, 2010 30. Name and address of person who completed eause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 9:20 p Eusebio Emilio Barrios ₽₹, 20**°**0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2706 Sheraton Street Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 65 Days XX M 2 T Months March Day Year 1944 578-86-6796 Nicaraqua Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ral", or items 23a Examiner must b Funeral 2706 Sheraton Street 20906 Nicaragua 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Nicaraguan White If Yes, Give Year or Dates 1 Mary Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Specify Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Cook Restaurant traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed trnent of Health and Mental H tant: If item 27 is marked of 0 Francisco Guillen Herminia Barrios 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lidia M. Barrios/Wife 2706 Sheraton Street, Silver Spring, MD 20906 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XXBurial 2 Cremation 3 Removal from State Jan. 2 2010 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Signature of Funeral Service Licer Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 rian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Gastric Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No n signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Lunknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performe After this certificate 1 Yes 2 No Yes 2 **3** No the Funeral Director: After this certifical pleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ျ 1 Yes 2xx No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv 2 Accident
3 Sui-X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

20

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Weitz, MD 7525 Greenway Center Drive, Greenbelt, MD 20770

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D23743

29d. Date signed (Month. Day. Year)

Jan. 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#19bperFH, 1/25/10, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day CAROL BENADON 2010 7:00 Medical January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖼 Days Hours Min Months 05/30/1936 Country) New York Yrs **Director** 130-28-1167 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Kensington Maryland | Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic ever ည Isreal Pine Evelyn Aranott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin Bergit and Number or Rural Route Number, City or Town, State, Zip Code) David Benadon, son 169 Bockman Lane, Hillsborough, NJ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematorium 01/22/2010 | Falls Church, Virginia Signature of Funeral Service Licensee 22. Name and Address of Danzansky-Goldberg Memorial Chapels MO1255 1170 Rockville Pike, Rockville, MD 20852 Part 1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Newmonio Physician/ griration disease or condition Medical resulting in death) consequence of Examiner XIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequ Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter Day Year Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ wid Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniurv 'Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 3 completed cause of death (Item 23a) (Type, Print) in 200 ny 20832 31. Date filed (Month, Day, State 0 Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ROBERT D. BOLLARD JAN 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RIDERWOOD SILVER SPRING MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 22, 1 Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F 480-18-2147 87 OCT. 1922 IOWA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 DOWNS DR. 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POSTAL MANAGEMENT INSTRUCTOR U.S. POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK J. BOLLARD **IDELLA** IRENE STRICKLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA BRYAN/DAUGHTER 9514 JACLYN CT., LAUREL, MD. 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-19-2010 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC PROSTATE CANCER Due to (or as a consequence of): Sequentially list conditions, Due to (or as a conse, uence of) trany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autonsy performed 1 ☐ Yes 2 XNo

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'sn'y injury or other traumatic event, the Wany injury or other traumatic event, the Wang none.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

2

if than "natural", or items 23a or 28a-f sho

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Exami burial-trar Physician/Medical ò Completed Be

Certification: To

Medical

State Registrar

29a, Certifier (Check only one)

and attending physician the the cate has t page 2 s certificate e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the letely filled in by the funeral

law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

within 24 hours aft To the Funeral Di completely filled in To the I within 2 To the I 5+1 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

29b. Signature and title of gertifier

27. Manner of Death 5 ☐ Pending investigation 1 XNatural 2 Accident 3 ☐ Suicide

6 Could not be determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

1 🔲 Inpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA

Injury at Work? 1 □Yes 2 □No

29c. License number

D09834

3720 FARRAGUT AVE., KENSINGTON, MD. 20895

Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6\(\text{Other} \) (Specify) \(\text{T.T.V.T.N.C.} \) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

JAN. 15, 2010

29d. Date signed (Month, Day, Year)

ivame and add	ress o	r person wno completed	cause of deat	n (Item 23a) (Type	, Prin
BARRY	N.	ROSENBAUM,	M.D.	3720	FA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Edward Butler State of Maryland / Department of Health and Mental Hygiene 2010 02830 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month **Medical Examiner** John Edward Butler 1531 hrs January 23, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Linder 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign MARY land) Country) **Funeral** 250.37.9333 Director 45 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Brandvwine PG s 23a or 28a-f show e notified at once. 28a-f show MD 1 Yes 2 No hours after death with the Maryland Director 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 115A 14210 Gibbons Church 20613 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 No Specify: Black Yes 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. College (1-4 or 5+) 1244 Handyman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Sylvester Doris Ann Be 19a, Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🗓 💆 Church Koad; Brandywine, MD Anael Coston Companion 14210 G1660ns 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) d/30/10 Beltsville, MD Inesapeake Cremator Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licenses Road: Temple Hills mo 2074 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Immediate Cause (Final disease a Cocaine and ethanol intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical XUNPENDED attending physician for use as the burial 23a,PII,27,28a-f,perm,E g900 2/4/10 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease Completed 24a, Was an 24b. Were autopsy findings available autopsy performed? death? page 1 🗸 Yes ✓ Yes 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 X No 24 hours after death. the 1/23/10 2:15 pm 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City, or Town, State) 14210 Gibbons CHurch Rd Brandywine, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined (Specify) residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca rithin 2 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day Year) O.C.M.E. January 24, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar Signatu

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Pay, 2010 Sarra Dolly CHERNICK 1:35 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chevy Chase 8101 Connecticut Ave., #500 South Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖔 F Sept. Day 28 ar) 84 1925 Carrada. Director 026-24-5664 Usual Residence of Decedent show 10a. State 10h. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified Chevy Chase Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8101 Connecticut Ave., #500 South 20815 United States 12. Was Decedent Ever in U.S. Armed Forcee?
1 ☐ Yes 2 Å No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rachel Poleshuk Samuel Tulchinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) $5711~{\tt Glenwood}~{\tt Road},~{\tt Bethesda},~{\tt MD}~{\tt 20817}$ Jeffrey Berman, Son-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 01/17/10 Olney, MD eral/Service Licensee Torchinskysshebitew Funeral Home 254 Carroll St., 20012 NW, Washington, DC 23a. Part 1. State the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition 4 Months Pnysician/ Esophageal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? 1 Yes 2 No after death.

Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA _4 □ Nursing Home 5 🛣 Residence 6 □ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pendina injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year, January 14, 2010 D 33293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave., Suite 1300, Chevy Chase, MD 20815 Р <u>Smith</u> Frederick Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 Year Gertrude Elizabeth Campbell January 18, 6:30 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Randolph Hill Nursing Home Wheaton Mon tgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** Sept. 1, 1925 1 □ M 2 🛣 F Months Days Hours Min. 579-30-6868 84 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏝 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2956 Beaverwood Lane 20906 TISA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 😾 No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Midowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Joseph Savoy Rosetta Savov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Brenda Stevens/Daughter 2956 Beaverwood Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 22 Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Clinton, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Senility disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year g Unknown 9 Unknown signed by Part II. **Other significant condition**s contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page The perform Yes 2 KN 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2X No ျ 1 Inpatient 2 ER/Outpatient 3 I 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760 P.0. Records, Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica eted filled in by the funeral director, <u>f</u> **Division of Vital** completed filled in by To the Hospital or within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gnoussa Sultana, MD 12107 Heritage Park Circle, Silver Spring, MD 20906 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D56691

29d. Date signed (Month, Day, Year)

January 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01715/2010 GEORGE UPTON COPELAND 0405 М 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min MD (Country) Months Days Hours 0771471930 79 220-28-7437 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20853 USA 12708 Turkey Branch Parkway 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes. Give Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Landscaper Lawn Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Bright George Thomas Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12708 Turkey Branch Parkway, Rockville, MD 20853 Thomas W. Copeland - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal fi 1/25/10 4 Donatjon 5 Other (Specify) Ardent Crematory Hanover, MD 21. Signature Funeral Service 22. Name and Address of Facility Snowden Funeral Home Washington St, Rockville, MD 20850 <u>246 N.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic shock disease or condition resulting in death) Due to (or as a consequence of): Methicillin resistant staphylococcal sepsis Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of) Acute respiratory failure that initiated events resulting in death) Last Due to (or as a consequence of Bilateral pulmonary nodules 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes mellitus autopsy death?

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

shov or 28a-f shov notified at

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ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be I

is marked other

permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni

hours after death

Maryland 21215-0036

Baltimore,

burial-transit and attending physician for use as the burial signed by the a To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should I Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has be a funeral Director.

that the death certificate be Box 68760

P.O.

Division of Vital Records,

Examine Physician/Medical Completed by Be ျပ Certificate:

Medical

29b. Signature and title of certifier

Vinu Ganti 31. Date filed (Month, Day, Year)

JAN 20

591

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IF FEMALE: performed?

1 Yes 2 No Acute renal failure 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D41162

29d. Date signed (Month, Day, Year)

01/15/10

DHMH 17 Rev 7/2009

State

Registrar

19529 Doctor Drive, Germantown, MD 20874

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eliseo Cidre 2010 :49 J<u>anuary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/03/193 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Months Days Hours Min. **Director** 578-56-9474 Spain Isual Residence of Decedent 10b. County or 28a-f shov 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6502 Rockhurst Road 20817 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 x Married within 72 hours after Maryland 21215-0036 1 🙀 Yes 2 □ No Specify: Spanish If Yes, Give "natural", Specify Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma Elementary/Seconday (0-12) College (1-4 or 5+) Renaissance Man Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benito Cidre Anuncia Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliseo Cidre Jr. / Son 8121 Huntfield Dr. Fulton, MD 20759 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2010 National Crematory Falls Church, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform Yes 2 X No 1 ☐ Yes 2 ☐ No ELISE Division of Vital 25. Was case referred to medical Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

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only one)

29b. Signature and the of certifier

31. Date filed (Month, Day, Year)
JAN 2 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1649

Lisa H. McGrail MD 5454 Wisconsin Ave. Chevy Chase, MD 20815

2. Registrar's Sign

29c. License number

D0065214

29d. Date signed (Month, Day, Year)

01/16/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State	of Marylan	-			d Mental Hy	giene	1.0	0.0	005
			Registrar	(4)		Cer	tificate of	Death		Reg. No.		UG	835
	Physicia		Decedent's Name (First, Middle, JoANN	Last) VIRGINI	Δ	CAMPBI	ET.T.		2. Date of De Month Januar	Dav	Year	3. Time of 5:25	
	Medic Examin		4a. Facility Name (if not institution,			Oznii Di	4b. City, Town, o	or Location of De			y of Death	J. 25	
	Examin	er	7010 Ridge		,		Frede				deric	k	
	Funeral			S. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of Bir	th	9. Birthp	lace (State o	r Foreign
	Director		220-34-0345	1 □ M 2 🔀 F	72	Yrs.	Months Days	Hours M	Sept.	1,119 37	Mary	land	
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	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
	with the 23a cast be	Funeral Director	7010 Ridge Ro	l .			217	02		United States			
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Nar	shoule h and h 7 is ma trauma		19a. Informant's Name/Relationshi						Rural Route Number				
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nor	Page 1 nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State C	emetery, cren	natory or other pla	- 11/1	5/2010		·		
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Important: If ii any injury or o		21. Signature Juneral Service Li		IKes		Memoria Name and Addre		ns	Frederi	CK, M	larylai	na la
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<u>.</u>	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unk		Jeaul 5	Other (specify) _					·	
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Sio	Attendation deat	ij	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be	e of Injury - At ho	ome, farm, stre	eet, factory, office			Street and Num.	ber or Rural	Route Numl	oe <i>r</i> ,
Division of Vital Records, P.O. Box 687	al or / s after I Dire		4 - Homicide determin	build	ing, etc. (Specif)	1)			City or To	wn, State)			- 4
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying (Check 2 Medical Ex	Physician: To the	pest of my know sis of examination	ledge, death on and/or invest	occured at the tim	e, date and plac	e, and due to the cred at the time, date	ause(s) and man	ner as state	d. use(s) and ma	nner stated
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			30. Name and address of person w		yeare (ten	0.23a)/Timo F		70007	MU	71	14 14	- 40	
1	0		Eugene B. Casag		6			ke. Fred	lerick. M	aryland	21702	2	
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Signa	ture 🥻	parked	,					
	Registra	ar	JAN	14 2010	Deneura	J fs.	7						

Registrar DHMH 17 Rev 7/2009

State

Robert Jackson, MD

31. Date filed (Month, Day,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

82 Thomas Johnson Court, Frederick, Marylad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ook Month Physician/ ver 20 Pear 1354 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Aug. 31 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Missouri 67 Yrs 1942 Director 498-46-6839 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Mount Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4394 Adam Court U.S.A. 21771 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White "natural", Specify: 3 Widowed 4 Divorced Completed al Hygiene. d other than "natura vent, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working U.S. Government Elementary/Seconday (0-12) College (1-4 or 5+) **FDA** Recall Coordinator 27 is marked other traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot ဂ္ 01iver W. Cook Mary Dereign 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4394 Adam Court, Mount Airy, Maryland <u>Beverly J.</u> Cook - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 Constion 5 Other (Specify) Neelsville Cemetery 1/20/2010 Germantown, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Fun ral Service Dicenses over 20872 26401 Damascus, Maryland Ridge Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). Cause (Disease or linjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day Yes 2 No signed by the a Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No certificate 2 1 No 1 🗌 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2-No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral to 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 2 010

Registrar
DHMH 17 Rev 7/2009

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32. Registra 's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 92838 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALAN BRUCE Month CARROLL January 2010 09:46 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 01ney 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 14 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 🗆 F Year) 195 Days Hours Min. New Mexico **Director** 563-88-2987 58 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director Md. Montgomery Brinklow 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Rivermist Court 20862 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1970—
If Yes, Give ģ Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced Specify: 1973 Year or Dates White other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. F.B.I. Agent U.S. Government 12 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charles Harvin Carrol1 Charlotte Macrae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele A. Carroll / item 27 1000 Rivermist Court, Brinklow, Md. Wife 20862 permit. Page 1 ar Department of H Important: If ite 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 1/21/10 Alexandria, any in 21. Signature of Funeral Service Licenses Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, 0-20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death aneurysm disease or condition Medical resulting in death) Due to (or as a co sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day 4 Pregnant a 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 ☐ No 2 X No Yes Division of Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 1 Minpatient 2 - ER/Outpatient 3 - DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes 2 No Investigation completed filled in by the Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CASAL 3 WM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Severna Park Anne Arundel 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 3. 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🔽 Months 167-10-7890 87 Director Yrs Pennsylvania Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10g. Citizen of What Country? 10f. Zip Code Funeral 864 Holly Drive South 21409 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Schork ၉ Alexandra Czernecka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Casali/son 864 Holly Drive South Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State Ft. Lincoln Crematory 1/19/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of funeral 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) SUNPISE examiner? Hospital Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

State Registrar 29b. Signature and title of ceftifie

JAN 19

leted cause of death (Item 23a) (Type, Print)

NIC

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia		Charles 3			rata							2. Date of De Month Januar		b, 20	Year	3. Time of Death 2:53 A ^M		
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X		118 Riverview Avenue							Annapolis						Arund	le1		
Funeral		K1				Age (In yrs. I	ast birthday) 77 Yrs.	If Under Months	1 Year_ Days	If Under Hours	24 Hrs. Min.	8. Date of Bir		020	9. Birth	place (State or Foreign		
Director		Usual Residence of Decedent					77116.					March 12,1932 Maryland				Tand	_	
and show	tor	10a. State	10b. County			10c. Cit	y, Town or Lo						10d. Inside City Limits	_				
Mary 28a-f otifie	Director	Maryland		runde	1	Ann	apolis							1 🗆 Yes 2🛣 No				
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shoul and l		19a. Informant's Na			•		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	er, City o	r Town, S	State, Zip	Code)		
and 2 Health em 27 ther to		Joan Camn 20a. Method of Disp		Wife		001				Ave.		napolis	1					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🖁 Burial 2 [☐ Cremation	3 🗆 Remo	oval from Sta	te Hi	Place of Dispo emetery, crea 11cres	natory or o	ne or ther plac	e)		Date -2010				own, State [aryland		
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Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death Onset and Death																
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Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	þ	Part II. Other signif	1	ons contribu	iting to death	but not res	ulting in the	inderlying o	cause giv	en in Part	I.					he cause of death?		
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sician: The law is certificate has but lirector, page 2 s		25. Was case referre	ed to medical						00.51			1 🗆 Yes	2 N	О	1 Yes	2 No	_	
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tendir leath. or: Af the ful	ifica	1-⊠ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pendin Investig 6 ☐ Could	gation not be				М	1 🗆	Yes 2 🗆	No							
or At after of Direct in by	Certificate:	4 Homicide	determ			njury - At ho etc. <i>(Specif</i> y	ome, farm, str	eet, factory	, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
spital		29a. Certifier 1	Certifying	Physician:	To the best	of my know	ledge, death	occured at	the time,	, date and	place, an	d due to the ca	ause(s) ar	nd mann	er as state	ed.	_	
To the Hospital or Attending Physician: within 24 hours after death. To the Luneral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2	🖳 Medical E	xaminer: 0	n the basis o	f examination	n and/or inves	tigation, in r	my opinio	n, death o	ccurred at		and place	e, and du	e to the ca	use(s) and manner stated	d.	
Vith vith con con		29b. Signature and	title of certifier	/	1	1		29c	License	number	~ ~ ;		29d. Da	ite signe	d (Month,	Day, Year)		
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gel	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										· M. 21047	7						
Stat	te	31. Date filed (Mont)	h, Day, Year)	110	82. Regis	strar's Signa	ture	- 1)_	U >(V . 36	7 V.	11)11	, ^	070	0. 411,)10-7-01		
Registra	ar	JAI	A T A 50	110	Penera	1 8	base	11										

DHMH 17 Rev 7/2009

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AMEND ITEM#30perDVR,G900,2/3/2010,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 18:04 p M Deljoui 20, 2010 Homayoun January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cheverly Prince George Prince Georges Hospital If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. Months Days 1 X M 2 □ F Yrs. 577-37-2209 64 04/05/1945 Iran Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evaniment ust be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Fairfax VA Herndon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2482 Masons Ferry Drive #102 20171 Iran 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Atomic Energy Organization Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Floranda Rahbani Mehdi Deljoui 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2482 Masons Ferry Dr. #102 Susan Deljoui /Wife Herndon, VA 20171 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chestnut Grove 01/27/2010 Herndon, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 721 Elden St. Adams-Green Funeral Home K. Bus Herndon, VA 20170 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 10 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death 2 1 ✓ Yes 2 ☐ No 24a. Was an 2 🗌 No 1 ZYYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat • Funeral Director: in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 4. 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 7525 Greenway Center Drive Ste. 309 Greenbelt, MD 20770 Daee 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

FEB 0 3 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician A^{M} Elizabeth Hampshier Devey January 2010 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montgomery 5555 Friendship Blvd. #521 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 579-10-3357 1 ☐ M 2 🔀 F Hours Director 90 10/29/1919 Canada Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evention and 10d. Inside City Limits Director MD 1 ☐ Yes 2 ▼ No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5555 Friendship Blvd. #521 20815 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No within 72 hours after 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Human Resource Manager United Nations permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Ayton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Reilley / Son Center Way Belair 5052 Australia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/21/2010 National Crematory Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final **Physician** Alzheimer's Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerty g Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Right hip septic arthritis 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐴 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division of Vital Records,

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

Shama R. Mittal,

JAN

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Segistrar's Signature

MD

29c. License number

D0061382

14816 Physicians Lane #152 Rockville, MD 20850

29d. Date signed (Month, Day, Year)

January 18, 2010

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Amend Item 26 per phys. G900 2/23/10 dk
State of Maryland / Department of Health and Mental Hygiene 02843 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 12:40p M 2010 /Medical John Hoover Dashiell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury
"Heder 1 Year | If Under 24 Hrs. 1704 Samuel Street Wicomico 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **™** M 2□ F Yrs Director 219-46-2533 61 2-13-1948 MDUsual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle r than "natural", or items 23s or 28s-f shorthe Medical Examiner must be nutified at 1 X Yes 2 ☐ No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code deeth with 1704 Samuel Funeral St. 21801 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o filed within 72 hours after d it Hygiene. other than "natural", or item Black, White, etc. 1 X Yes 2 No Army If Yes, Give Year or Date 1:970-73 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MD Department of Elementary/Secondary (0-12) College (1-4or 5+) Transportation 11 Driver i. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: if Item 27 is marked other ti jury or other treumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Irene Dashiell Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shelia P. Dashiell/Wife 1/04 Date of Disposition (Name of cemetery, crematory or other place) 1704 Samuel St, Salisbury, MD 21801 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Zion UMC Cem 1-23-2010 Quantico, MD 21. Signature of Funeral Secrete licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Salisbury, MD 21801 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER TONGUE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COUON CANCER 1 Yes 2 No 3 Probably 4 Unknown YNE MIAMETA MALITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HERATITIS 1 Yes 2 No 2 No 1 ☐ Yes Vital To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes / 2 No 2 2 ER/Outpatient 3 DOA this Division of 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19 HYSIUM

DHMH 17 Rev 1/2001

State Registrar CAMBRICKE OPC 830 ChESapeule De. CAMBRICK, NO 216/3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- TERSON

JAN 20 2010

32. Registrar's Signature

ENCHUTAL, Story

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4 10 A M January **JENNIE** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 □ M 2 🕱 F DEC 1 1925 West Virginia Director 218-24-1671 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Knoxville MD Frederick 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21758 4110 Shady Lane ral", or items? 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 😾 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollie Hoar Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4741 Catholic Church Road, Knoxville, MD Marian Reynolds, Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mark s Cemetery 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Petersville, MD 1/20/2010 4 Donation 5 Other (Specify) 21. Sig Mure of Funeral Service Licens any in 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, Barbara A. Williams 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocard disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ears orono Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) g Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2260360278 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NND021230 16 2010

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registral's Signature

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21516 Cm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Thomas Ellingsworth Month Physician/ Lee 2010 Medical 4a. Facility Name (if not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER **Examiner** Town, or Location of Death SALISBURY County of Death WICOMICO Age (In yrs. last birthday) . Social Security Number 222–28–7529 8. Date of Birth (Month, Day, Year) 02/16/1944 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Hours Country)
Maryland Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 🛛 No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 7500 Madeline Circle 21849 items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yès 2 ☐ No If Yes, Give National Year or Dates. Guard Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Divorced 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) clerical banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Orlando Parker Ellingsworth Helen Mae Parker and 2 should b Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7500 Madeline Circle, Salisbury, MD 21849 Marsha Ellingsworth/spouse permit, Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Anatomy Gifts Registry 1/19/10 Hanover, MD P. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 CFSF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastano disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): ng physician ar as the burial-t resulting in death) Last Physician/Medical P.O. Box 68760 signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 certificate 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E egistrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#29 dperMD, 1/26/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jerrye E. Embrev Jan. 13, 2010 2:10 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Hyattsville Prince Georges 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months 1 M 2 TXCE Days Hours Min. 94 577-12-7373 July 2,1915 Texas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XYes 2 No Hyattsville Md. Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Queens Chapel Road 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Director of Elementary/Secondary (0-12) College (1-4or 5+) Community Relations Ferris & Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Embrey Ann Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith O'Hara/Attorney 3400 McKinley St., NW., Washington, DC 20015 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 25, Jan. Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature J Functal Service Lice 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multi Organ Failure Weeks disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Osteoarthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating that he in tithes at any Injury or other traumatic event, the Medical Examinating that he in tithes at any Injury or other traumatic event, the Medical Examination and once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Examine burial-tra attending physician for use as the buria Physician/Medical ned by the δ cate has been sign page 2 should be Completed certificate funeral director. Be Certification: To this After t s after dea. ral Director: Aft filled in by

27. Manner of Death

Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli, M.D., 10810 Darnestown Road, #202, Gaithersburg, Md.

State Registrar

Medical

31. Date filed (Month, Day, Year) 32 Registrar's Signature JAN 20 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20 (C 0112 RANDY **EDWARDS** JANI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Levery Prince 01 If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea ay 21, 1 1 □ M 2 🕱 F Months Days Hours Min. **Director** May 577-72-9038 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ä Director Examiner must be notified -28a-f Washington 1 Yes 2 No D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 20019 202 35th St., N.E. United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 9 δ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Specify: "natural" Completed 3 Widowed 4 Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Maintenance Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James A. Armstrong, Jr. Joyce Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Edwards / Daughter 2008 Franklin St., $_{
m NE}$ Wash., DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory! 1-25-10 Beltsville, Md. f Funeral Service 22. Name and Address of Facility 21. Signa Capitol Mortuary, 20002 NEMaryland Ave., complications that caused the death. Do the enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease Approximate shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final √nysician/ rTeriose 2101 disease or condition resulting in death) 5.0500 Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any leading to in medicause. Enter Underlying Cause (Disease or iinjury that initiated events Date to for each nonnectioning off requires that the death certificate be executed anding physician and use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Pregnant at time of death 5 Other (specify) 2 No certificate has been signed by the a rector, page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed' Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Dav. Year)

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State Registrar 300

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan. 14° 2010° Theodore Earle 9:10 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Spa Creek Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 78 Months Hours Min (Month, Day, Year) 1XXXM 2 II F 217-32-8929 MD Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director MD Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Examiner must be Funeral 23a 2503 Painter CT. 21403 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2XX No Black White etc ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2XX No Specify: White If Yes, Give Year or Dates and Mental Hygiene.
is marked other than "natural", 3 Divorced 4 Divorced Completed injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Grocer Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael Earle Ida Rosenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health al Important: If item 27 is <u>Steve Earle</u> Son Painter Ct. Annapolis. MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Kneseth Israel Cemetery 1/17/10 Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee any. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Uncertying Cause (Disease or iinjury Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p use as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 ☐ No s been signed by the should be detached q 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20010 3 Probably 4 Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **Quatural** 5 Pending work?
1 \(\subseteq \text{Yes} \) 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tale of certifier

Registrar

DHMH 17 Rev 7/2009

State

30 Name

31. Date filed (Mor

and address of

person who completed cause of death (from 23a) (Type, Print)

eneur

egistrar's Signatur

32136

Dorch Drive

Amend #17 per FH Please Type or Print in Black Indelible Inki of nourae All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene AACO Health Dept 1-19-10 KH 1- State Registrar Certificate of Death 2010 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 12 -2009 8:55P M **Physician** Jan. Nettie Elizabeth Fox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Watts Group Assisted Living Severn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 XF Yrs. 217-44-9327 8/15/1914 West VA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rectified at 10a. State 1 ☐ Yes & No Director Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 21114 USA 1670A Carlyle Dr. Funeral 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🏚 No Specify: White þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . 121.
. and 2 should be filed within 72 f Health and Mental Hydrorene 27 is mark-Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 17 Father's Name (First, Middle, Last) Clarence Clarence Livesay 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Hardburger ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1670A Carlyle Dr. Crofton, MD 21114 <u>Elinor Harvey</u> Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 1/16/2010 Davidsonville, MD Lakemont Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 178 - 2 Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li-Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Hospital or Attending Physician: The 2 🗆 No 1 ☐Yes 2 ☐Mo 1 ☐ Yes Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Assisted Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{5}\square$ Other (Specify) Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this of funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation in 24 hours after death.
The Funeral Director: After the funeral Director. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated To the Within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ass of person who completed cause of death (Item 23a) (Type, Print) billy

Registrar

State

Registrar's Signature

ORIGINAL

Registrar

Box 68760

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of Vital Records,

JAN 19 2010

State Registrar DHMH 17 Rev 7/2009

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29b. Signature and title of certifie

31. Date filed (Month, Day,

an m

JAN

Year,

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRITCHER

68760

Box

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2. Registrar's Sign

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Nertificate of Death		ene _{1. No.} 2010 02852		
	Dhysioic	·n/	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death		
7	Physicia Medi		Robert Allen Goldwin		January	12, 2010 3:17 a M		
	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
	Funeral		Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Rockville If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	th Montgomery 9. Birthplace (State or Foreign		
	Director		088-14-2846 1 X 2 F 87 Yrs.	Months Days Hours Min.	04/16/19	22 New York		
0	nd at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits		
~	larylar 3a-fsl iffied	Director	Maryland Montgomery Bowie			1 ☒ Yes 2 ☐ No		
ţ	the M		10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Country?		
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	10450 Lottsford Road #135	20721		USA		
	r deat	F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
920	s after ral", o Exam	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ X2 Yes 2 ☐ No If Yes, Give Year or Dates. WWTI	1 ☐ Yes 2 💢 No Specify:		Specify: White		
21215-0036	natur dical	Completed	15. Decedent's Education 16a, Dec	redent's Usual Occupation re kind of work done during most of work	ring 16	b. Kind of Business Industry		
121	thin 72 ne. than '	l E	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)		44.4.4.9.91.41.1		
	filed wit al Hygie d other vent, th	Be	5+ Resi	dent Scholar, AEI	ne (First, Middle, Maid	olitical Philosopher		
lan	l be fill hental rked c	卢	Alexander Goldwin	Sed App		den Sumame)		
Maryland	should be file and Mental F is marked o raumatic eve	П	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Run		ty or Town, State, Zip Code)		
	and 2 s Health tem 27 other tra				edar Cres	t, New Mexico 87008		
lore	w 0 = =		20a. Method of Disposition 20b. Place of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition	position (Name of ematory or other place) Israel ation Cemet. 01/1	Date 20	c. Location - City or Town, State		
Baltimore,	ヨモモラ					nnapolis, Maryland		
Ba	Depar Impo any ir	0 0	MO1255	22. Name and Address of Facility EDWARD SAGEL FUNER 1091 Rockville Pik	AL DIRECT e, Rockvi	ION, INC. lle, Maryland 20852		
ч			23a. Part 1. Efter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between		
a	mysician, Medical	1	Immediate Cause (Final disease or condition resulting in death) Empyema a. Empyema			Onset and Death		
-	Examiner		Due to (or as a consequence of):					
7		iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying					
P	cuted and transit	Examiner	Cause (Disease or impury that initiated events C					
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	alE	resulting in death) Last Due to (or as a consequence of):					
Box 68760	cate r	Physician/Medical	d					
89	eath certificate attending phy for use as the	N/us	FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of delivery		
Bo	death he atte ed for	sici		Other (specify)		Month Day Year		
P.O.	at the d by tl letach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did tobac	co use contribute to the cause of death?		
S, P	requires that the de been signed by the should be detached	d by	Upper Gastrointestinal Bleeding	, 3		2 No 3 Probably 4 X Unknown		
ord	v requisited should	olete	Aspiration Pneumonia		24a. Was an	24b. Were autopsy findings available		
of Vital Records,	The law ate has page 2	Completed	Respiratory Failure		autopsy performed 1 Yes 2X			
tal.	certificate rector, pag		25. Was case referred to medical	26. Place of Death (Check		110 100 2 110		
Ž	Physician: this certificinal director, I	유	1	of Land and Land and Table 1		e 6 🖔 Other (Specify) Hospice		
0 0	th. After funer	Certificate:	27. Manner of Death 28a. Date of injury 28b. Time 1		28d. Describe how i	njury occurred		
Division	Aften er deal ector: by the	rtifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s			t and Number or Rural Route Number,		
Di	Ital or Irs afte al Dir		building, etc. (Specify)		City or Town, S			
:	or the hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical	29a. Certifier (Check Check only one) Certifying Physician: To the best of my knowledge, death the check only one) Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at	t the time, date and p	lace, and due to the cause(s) and manner stated.		
:	vithin To the		29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)		
	D		J. Kouerchou, mi)	263748	Ј	anuary 13, 2010		
	•		30. Name and address of person who completed cause of death (Item 23a) (Type,	· ·	n-1.	MD 01010		
	Sta	 	Jocelyne Toukep Kouatchou, MD 201 Ea 31. Date filed (Month, Day, Year) 22. Registrar's Signature		, Baltimo	re, MD 21218		
	Registra		JAN 20 2010 Centre B. Bas	KI				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 11:30am 2010 Arnold Grolnick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 221 Booth Street. Gaithersburg Montgomery If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo Aprul 10 Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** Days 1 🕅 M 2 🗆 F Hours Director 557-62-1921 61 New York Usual Residence of Decedent shov 10h Counts 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Director 1 Yes 2 No Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with #315 20878 U.S.A 221 Booth Street. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married þ 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. < Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify. 3 Widowed 4 X Divorced Completed Caucasian Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Carpet Cleaner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Frank Grolnick Leona Perestock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health an
Important: If item 27 is
any injury or other traus Carol Heltzer - Sister 654A Main Street, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 01/15/2010 | Clarksburg, Maryl<u>and</u> 4 Donation 5 Other (Specify Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Myocardial Infarction disease or condition Medical resulting in death) Examiner ASHD Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit Hupertension Due to (or as a consequence of): resulting in death) Last tate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ္ဝ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 31. Date filed (Month, Day, Year) JAN 20 2010

Betsy Ballard, DME,

29b. Signature and title of certifier

2101 Medical Park Drive, Suite 304, Silver Spring, MD 20902 registrar's Signature MUM

DN 15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2+1

MD29018

29d. Date signed (Month, Day, Year)

January 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Ophelia Marie Gatlin 2010 8:50 Jan. /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth (Month, Day, Year) とらられ 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 83 578-34-4532 Aug. 8, Director 1926 DC Usual Residence of Decedent 10d. Inside City Limits the Marylan 10a State 10b. County 10c. City. Town or Location 28a-f show ns 23a or 28a-f shor 1⊠Yes 2∏No Director Maryland Prince George's District Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 United States 1508 Shady Glen Drive Funeral ltems ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, I'm Mulcal Examine once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: African 1 ☐ Yes 2 No altimore, Maryland 21215-0036 ģ Specify 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12th \end{array}$ College (1-4or 5+) Maintenance Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Ullysses Johnson Marie Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Shady Glen Dr. District Heights, Md. 20747 Kenneth Dwight Gatlin/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 2010 Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sunature of Funeral Service Lio 20019 Washington, DC 4001 Benning Rd. NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 Ø No ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown as leen si 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate 1 □Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. completed cause of death (Item 23a) (Type, Print) envery Center PM State Registrar

DHMH 17 Rev 1/2001

		_	For State Registrar	State of Maryla	-	artment of F		R	leg. No. 2010	02855	
	Physicia		Decedent's Name (First, Middle, Last Barbara JoAnne	•				2. Date of Dea Month January	Day Year	3. Time of Death 12:20 P. M	
7	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death	1	4c. County of Death	1	
, AS			7025 Marbury Co		1 111111	Dist:	rict Heigl		Prince Ge	eorge's	
	Funeral Director		5. Social Security Number 6. S 578-84-8382 Usual Residence of Decedent	D M 2 🖾 F 51	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 11/30/1	(, Year)Co.	untry) • , D.C.	
	yland		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits	
	e Mar Ba-fsl	ctor	D.C.	V	<i>l</i> ashing	ton				1. Yes 2 No	
	or 28	Dire	10e. Street and Number			10f. Zip Code	00	1	10g. Citizen of What Co	untry?	
	eath v	Funeral Director	1635 Kramer St. 11. Marital Status	, N . E .	118 13	200		ecify Yes or No-	U.S.A. 14. Race - American Indian,		
2-0030	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I Hygiene with the Tris marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evertines must be notified at	by	1 Never Married 2 🖾 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 🌠 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specific Af		
	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Business/I	ndustry	
7	filed within Hygiene. other than ' ent, the Me	duic	Elementary/Secondary (0-12)	College (1-4or 5+) 1 year		DO NOT use retired aims Exam	•		Private Ind	lustry	
	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last,		CIC	ATING LINGIN		e (First, Middle,	Maiden Surname)		
<u>a</u>	should be ind Mental marked o	To B	Robert West				JoAnne	E. King			
5	and 2 shor ealth and h n 27 is ma		19a. Informant's Name/Relationship (Jerry Goodwin/Hus						r, City or Town, State, Zon, D.C. 200		
pallimore	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			esition (Name of matory or other place Cremato		Date 01/22/10	20c. Location - City or Beltsville		
Dall	permit. Depart Import any inj		21. Signature of Funeral Service Licer	N Crall	49	2. Name and Address H.S.Wasi 25 Burro	nington & ughs Ave.	Sons Co	o.,Inc. ashington,D	.C.20019	
П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
· F	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Advanced						Offset and Death	
, str	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a conse	equence of):						
Ď,	ricate be executed physician and sthe burial-transit		that initiated events resulting in death) Last	C Due to (or as a conse	equence of):						
00/00	physics the the the the the the the the the the	edical	•	d							
O. DOX	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown		23d. Date of delivery Month Day Year						
ν, Γ	es that the signed by pe detact	by Ph	Part II. Other significant conditions of	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.		obacco use contribute to	the cause of death?	
cords	requi	eted						1 U Y	- X		
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N Ea	this certificate al director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only or	ne)		
5	this c	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2					ience 6Other (Spe	Mother's Residence	
SION OF	anding rath. or: After he funer	ation:	27. Manner of Death 1 Natural 2 Accident Accident S Pending investigation		28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred		
<u></u>	ral or Att s after de al Directo ed in by t	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, str cify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or Ru n, State)	ıral Route Number,	
:	lo the hospital of Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Example (Check only one)	nysiclan: To the best of my k miner: On the basis of exami and manner stated.	nowledge, dea nation and/or ir	th occurred at the ti nvestigation, in my	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and manner at date and place, and due	s stated. to the cause(s)	
	Vithi Vithi COM	Ž	29b. Signature and title of certifier	mlut. M		29c. Licens D685			29d. Date signed (Monto anuary 20, 2		
D	2		30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)					
1		10	Piyapong Vongkov 31. Date filed (Month, Day, Year)	it M.D. 1221 32. Registmar's Sig	Mercant	ile Lane,	Largo,Mar	yland :	20774		
	Sta Registr		Piyapong Vongkov 31. Date filed (Month, Day, Year) JAN 2 1 2010	Zenera D. A.	barke						
DUIL	IH 17 Rev 1/2	004	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jaliuary 17, Day 2010 2:35 P Physician/ William Alton Gallahan III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12300 Gallahan Road Clinton Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1**XX**M 2 □ F 02909/1933" Washington, DC Director 218-38-7742 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2XXNo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12300 Gallahan Road 20735 TISA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give 1954 Year or Dates. 1958 þ Maryland 21215-0036 1 ☐ Yes 2 xxNo Specify. Specify White 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self - Employed Farmer 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Α. Gallahan Jr. Emma Xander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Patricia D. Gallahan / Wife 12300 Gallahan Road Clinton, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State 1/21/2010 St. Mary's Ch. Cemetery Clinton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatur of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 (and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to for ge's consequence of Cause (Disease or linjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) burialthe attending physician To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of Yes 2 XXNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 I DOA မှ 4 Nursing Home XXXXesidence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury X Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical KKcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JAN 19, 2010 MD 0035067 ee

DHMH 17 Rev 7/2009

State

Registrar

109-1.UA

Barke

Deepa S. Subramaniam, MD 3800 Reservoir Rd., NW, Washington, DC 20007

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 19 2010

31. Date filed (Month, Day, Year)

			For	State o	f Marylan	•				lental Hy	giene		
			State Registrar			Cer	tificate (of Dea	ath		Reg. No. 2	LLO	02857
	Physicia Medic		Meliga Garcia-Herrera									Year 2010	3. Time of Death 4:05 A M
	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death							4c. County of Death			
. •			Doctor's Hospi 5. Social Security Number 6		7. Age (In yrs. la	at hirthday)	Lanha If Under 1		Under 24 Hrs.	8. Date of Bird			orge's
	Funeral Director		551-79-1131	1 ☐ M 2 🔏 F	61	Yrs.			ours Min.	10/9/15/9		Cour	prace (State or Foreign arragua
	nd how at	۲	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation	_					10d. Inside City Limits
	larylar 3a-f sl iffied	Director	MD Prince	George's	s Upp	er Mar	lboro						1 🗌 Yes 2 🞽 No
	the N		10e. Street and Number				10f. Zip Co	ode			10g. Citizen of	What Cou	intry?
	h with	Funeral	11901 Chestert					2077			USA		
٥	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed Ford d 1 ☐ Yes	2 🔀 No	if	Yes, specify	Cuban, Me	nic Origin? (Spe lexican, Puerto	Rican, etc.)	Bla	ck, White,	can Indian, etc.
9500-612	urs afi tural",	ted	3 Widowed 4 M Divorced	If Yes, Give Year or Da	e ites.				^{pecify:} Nica	raguan	Specify	Lat.	
2	72 hor r "nat ledica	Completed	15. Decedent' (Specify only highest			16a. Deced	ent's Usual C	occupation			16b. Kind of B	usiness In	ndustry
717	vithin liene.		Elementary/Seconday (0-12)	College (1- 2	-4 or 5+)		mstres	,			Cloth	ing	
מ	filed value of othe	o Be	17. Father's Name (First, Middle, Lat								Maiden Surnam	e)	
Za	uld be I Ment narke	욘	Anacleto Herre				-			a Chava			
Maryland	2 sho th and 27 is r traum		19a. Informant's Name/Relationship Rita V. Garcia		er		g Address (S Chest				r, City or Town, S Marlbor		
ō,	f and f Heal item other		20a. Method of Disposition		20b. P	lace of Dispo:	sition (Name	of		Date	20c. Location		
Ē	Page nent o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp			emetery, crem view (1/15	/2010	Baltimo	re, l	MD
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral ervice of	ensee							eral Hom	e 207	1 5
			23a. Raft 1. Enter the sease, or c	om dications hat o	aused the death				in Hwy. uch as cardiac o		vie, MD rest,	207	Approximate
	Physician/		shock, or heart Ailure. List on Immediate Cause (Innal disease or condition	ly one eause on ea	ch line. h A o m	. 0			Corre				Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a consequ		/	0	C3-1	7001708			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as a consequ	ынва сбу.							
	ecuted and I-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	or as a consequ	ence of):						-	
S	s be ex ysician e buria	dical		d									
9/89	tificate ng phy as the	ı wı	IF FEMALE:										
Box 6	ath cer attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 🔲 Live	come of pregna Birth 2 Feta nant at time of c	ıl death 3 🗔	Ectopic pre				I .	ate of deliventh	very Day Year
	the de by the ached	hysi	9 🗆 Unknown	9 🗌 Unkr	nown								
s, P.O	signed det	by	Part II. Other significant condition Anemia	s contributing to d	eath but not res	ulting in the u	nderlying cau	use given ir	n Part I.	23e. Did t	/		the cause of death?
Vital Records,	w requ	Completed	Renal Fo	ulive						24a. Was auto			opsy findings available ompletion of cause of
Ř	The la ate ha	Com								perfo	ormed? 2 No	death?	2 🗆 No
ta	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:				Other:	of Death (Check				
ot o	g Phys er this eral di	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2 of injury th, Day, Year)	28b. Time of injury		. Injury at work?		-	dence 6 🗌 Oth now injury occur		<u> </u>
0	eath. or: Af	ficat	1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could n	ation			М	1 🗌 Yes	2 🗆 No				
Division of	l r Att	Certificate:	4 Homicide determin	28e. Place	of Injury - At ho ng, etc. (Specify		eet, factory, o	office			on (Street and Number or Rural Route Number, r Town, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours at lear death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex	Physician: To the base aminer: On the base Nurse Practioner:	sis of examination	n and/or invest	tigation, in my	opinion, de	eath occurred at	the time, date	and place, and du	ie to the ca	ause(s) and manner stated.
	To th within		29b. Signature and title of certifier	llero	ler			icense nur		-	29d. Date signe		Day, Year)
	DX H		30. Name and address of person w		se of death (Item	23a) (Type, F	Print)		2		2	M A	20720
	Sta	te	31. Date filed (Month, Day, Year)	X4NDEA 32. R	legistrar's Signat	ture		025	ROME	SE DR.	DEWIE,	MD	20100
	Registr		JAN 19 2010	12	1	hon V	1						

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 1140 NCENT Year GUIDICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel House Harwood If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York 1 ☑ M 2 □ F Months Days Hours Min 82 **Director** 128-16-2691 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Bowie 1 X Yes 2 No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 12709 Kembridge Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 1945–49 Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 nr th and Mental Hygiene. 27 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electrical Engineer NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ဂ္ Arthur Guidice Rosaria Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doria Klakring/Daughter 12709 Kembridge Drive, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Catlett Methodist Cemi. 01/18/2010 Catlett, Virginia 4 Donation 5 Deher (Specify) 21. Signature of Funeral Prvice Licensee 22. Name and Address of Facility Beall Funeral Home <u>6512 NW Crain Hwy., Bowie, MD 20715</u> 23a. Part 1. Enter the diseas implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List Interval Retween Immediate Cause (Final UNG Now The Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. rany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence or, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death this certificate has been signed by the all director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗀 No Yes 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? MANORIN Hospital Other: 1 Tes ရု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No PICE 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending M Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify, To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certife 29c. License number 1320/0 UDN

DHMH 17 Rev 7/2009

State

Registrar

lame and address of person

JAN19

ise of death (Item 23a) (Type, Print)

Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland		irtment o <i>tificate o</i>				giene Reg. No.	2010	02859	
ı	Physicia		1. Decedent's Name (First, Middle, a Bertha Goebel	Last)					10	2. Date of De Month 16	ath	N.	3. Time of Death 331 M	
	Medic Examin		4a. Facility Name (if not institution, g Baltimore Wash		al C	enter	4b. City, Town	n, or Locatio Len Bu			4c. County of Death Anne Arundel			
Ī	Funeral Director					st birthday)	If Under 1 Ye Months Da		der 24 Hrs s Min.	8. Date of Bir 3/96t/, Pe			thplace (State or Foreign untry) NY	
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County	A 1 - 1	10c. City,	, Town or Loc		nbrill	l c				10d. Inside City Limits	
	the Mary or 28a-l	Funeral Director	MD Anne 10e. Street and Number	Arunde1			10f. Zip Coo	e	-		10g. Citi:	zen of What Co	1 ☐ Yes 💥 No	
	eath with tems 23s er must t	-unera	925 November C	12. Was Decedent E	ver in U.S.	. 13. V	Vas Decedent o	21054	Origin? (Spe	cify Yes or No-	1.	USA 14. Race - Ame	erican Indian,	
980	rs after d iral", or i	by	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		Yes, specify C						ack, White, etc. White fy:	
Baltimore, Maryland 21215-0036	iin 72 hou ie. han "natu e Medical	Completed	15. Decedent' (Specify only highest Elementary/Seconday (0-12)		+)	(Give k life. DC	ent's Usual Oc ind of work do NOT use retir	ne during m ed)	ost of worki	ng		nd of Business	·	
nd 21	be filed with ental Hygien ked other tl ic event, the	Be	12. Father's Name (First, Middle, La.	st)		Но	omemake	18. Mc		(First, Middle,	Maiden S	own Hom	<u>e</u>	
laryla	should be and Ment is marke aumatic e	욘	Albert Kretzschmar Bertha VanElkan 19a. Informant's Name/Relationship (Type, Print) Carolyn Hopke Daughter Bertha VanElkan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat 952 November CT. Gambrills, MD 21054										p Code)	
re, M	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Carolyn Hopke Daughter 952 November CT. Gambrills, MD 21054 20a. Method of Disposition (Name of Cemetery, grematory or other place) Date 20c. Location - Ci										Town, State	
altimo	mit. Page partment portant: I / injury o		4 Donation 5 Other (Sp	ecify)		mont 1	Memoria . Name and Ad	1		0/2010			11e, MD e, P.A.	
Ä	permir Depar Impor any ir		23a. Part 1. Enter the disease, or c				2 Ridge		e. Ar	napoli	s, MI	21401	Approximate	
Ŧ	Priysician/ Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	1)	men								Interval Between Onset and Death	
	Examiner	er												
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or inipury that initiated events resulting in death) Last C											
09,	cate be executed physician and s the burial-transit	edical 1	,	d										
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	I Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy									23d. Date of de Month	livery Day Year	
ls, P.O.	uires that the signed by ald be detact		Part II. Other significant condition	s contributing to death b	ut not resu	Ilting in the u	nderlying cause	glven in Pa	art I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 No 3 Probably 4 Unknown			
Division of Vital Records, P.O.	: The law rec cate has bee , page 2 sho	Completed								24a. Was auto perfo 1 \(\sum \) Yes		prior to death?	ntopsy findings avallable completion of cause of	
Vital	ysician iis certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 💢 E	ER/Outpatien		Other:	eath (Check Nursing Ho	ne 5 Resi	dence 6	Other (Spe	pify)	
on of	nding Phath. r: After the funeral	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga	ition	y ; Year)	28b. Time of injury	V	njury at vork? Yes 2		28d. Describe I	now injury	occurred		
Division	al or Atte s after de al Directo		3		ry - At hor . (Specify)	me, farm, stre	eet, factory, offi	ce		28f. Location (8 City or Tov		Number or Ru	ral Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	kamination	and/or invest	igation, in my o	oinion, death	occurred at	the time, date a	and place,	and due to the	cause(s) and manner stated.	
	Vith Vith Con Con Con Con Con Con Con Con Con Con		29b. Signature and title of certifier	MD				ense numbe 389			1	signed (Mont) $16/20$		
	50		30. Name and address of person w		ath (Item	23a) (Type, P	rint)	Com	SW	Colin	Bur	ne 1	10 1021061	
	Sta Registra		31. Date filed Month, Pay, Year AN 19	2010 32. Registra	r's Signatu	A. A	barks	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GAWER S, IN OR Physician/ 0930 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min ear 1918 NEW YORK JANUARY 13 060-14-2643 92 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 1 Yes 2X No ANNE ARUNDEL ANNAPOLIS MARYLAND 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? UNITED STATES 21401 800 BESTGATE ROAD, #242 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 0 ò 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o ည ELINOR NOSTRAND DeBEVOISE WALTER SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELINOR D. GAWEL/DAUGHTER 144 LEE DRIVE, ANNAPOLIS, MARYLAND 21403 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION JANUARY CENTER 4 Donation 5 Other (Specify) 2010 STEVENSVILLE, 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 Signature of Funeral Service Lig Will Elove M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate grval Between and Dea Immediate Cause (Final Priysician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) No detached P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate 2 🗌 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes မှု 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours—fter death.

To the Funeral Urector Air completed filled in by the fu 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nature and title of certifi 2010 mpleted cause of death (Item 23a) (Type, Print) 21401 NNAPOUS FNSE ENTH 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perFH,G910,6/28/2011,WS
State of Maryland / Department of Health and Mental Hygiene? For State State Registra AMEND#7+20bperFH, 1/15/2010, BMW, Moco Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ronnie Howard Calvin Physician/ 2010 6:45pm January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges **Examiner** Riverdale 5918 Somerset Road 7. Age (In yrs. last birthday) 46 _47_ vrs Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1962 9. Birthplace (State or Foreign **Funeral** Min XXM 2 D F Months Days Hours New Jersey 143-60-4759 Jul 11, 1963 47 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Riverdale Prince Georges M D 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 20737 5918 Somerset Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, et by 1 Never Married 2 X Married Maryland 21215-0036 African 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced A merican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 72 ene. Elementary/Seconday (0-12) College (1-4 or 5+) Project Operational Manager Roadway Express of Health and Mental Hygien If item 27 is marked other the r other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked or မ John Howard Pearl **Atkins** permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Ann Howard / wife 5918 Somerset Road, Riverdale, Maryland 20737 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Glewood Centerer place) Washington DC Comotory 1/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Rock McGuire Funeral Service, Inc. Signature of Funeral Service Licensee 22. Name and Address of Facility Rndré 20012 Mes 7400 Georgia Avenue, NW, Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrest Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Nicotine Addiction certificate be executed Due to (or as a consequence of): resulting in death) Last Glucose Intolerance Physician/Medical P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ death o in the past 12 months? Month Day Year Pregnant at time of death Tyes 2 □ No ed by the a 9 Unknown 9 Unknown signed by the sign of the sign of the details Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tohacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed' 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital 2 X No al or Attending Physics after death.
I Director: After this or din by the funeral dire 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral I Hospital Medical 1XXCertifying Physician: To the best, my kin wledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best, my kin wledge, death occured at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Prectioner: the best only one) 29b. Signature and title of confiner 29c. License numbe 29d. Date signed (Month, Day, Year) 2 D0026556 January 12, 2010 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 7350 Van Dusen Road, suite #130, Laurel, Maryland 20707 Seth Eaton, MD 31. Date filed (Month, Day, Year) 32. Fegistrar's Sign parked State

Registrar

Physician 0805 ^M 14, Iva T. Horner January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 305 Pacific Avenue Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Country) **Funeral** Months Days Hours Min 05/05/1920 1 □ M 2 F 218-10-8155 89 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD Salisbury Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 305 Pacific Avenue 21804 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Bank is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lafayette Townsend Mary Hudson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; If item 27 any injury or other tr. once. Susan Johnson (Executrix) 224 Sandy Bottom Court Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 18, 2010 4 ☐ Donation 5 ☐ Other (Specify) Whatcoat Methodist Cem Snow Hill, Maryland 22. Name and Address of Facility Short Funeral Home 13 East Grove Street 21. Signature of Funeral Service Licenses 4 19940 Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and DEMENTIA Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached Ö 9 Unknown 9 Unknown <u>ت</u> 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

1. Decedent's Name (First Middle Last)

investigation

MADARANG - LEWIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

104

State of Maryland / Department of Health and Mental Hygiene \(\)

2. Date of Death

3. Time of Death

Registrar DHMH 17 Rev 1/2001

neral Director: , filled in by the f

ical

Medi

State

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

S.

32. Registrar's Signature

1 Yes

050929

DIVISION ST. SALISBURY MD 21804

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1-14-10

			State of Maryland / Der	partment of Health and M	•	ene	
		•	FOR	ertificate of Death	, ,	9. No. 2 A I A	02864
		,	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medic		Miriam Halpern		January	15, 2010	1:00 рм
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
ممسد			321 University Blvd. West 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Silver Spring If Under 1 Year If Under 24 Hrs.	0. D.A (Dist.	Montgomer	-
	Funeral Director		5. Social Security Number 6. Sex $1 \square M 2 \nearrow F$ 7. Age (In yrs. last birthday, $77 - 77 - 77 - 77 - 77 - 77 - 77 - 77$		8. Date of Birth Month, Pay, Ye	ear 932 9. Birth	place (State or Foreign htry) 4 D
-			Usual Residence of Decedent		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	f shord	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-i otifie	Director		r Spring			1 🕅 Yes 2 □ No
;	th the	alD	10e. Street and Number	10f. Zip Code	191	g. Citizen of What Cou	
	ms 2 mus'	Funeral	321 University Blvd. West 11. Marital Status 12. Was Decedent Ever in U.S. 13	20901		United Sta	
_	or dea	by Fi	1 Never Married 2 Married 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Spe- If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White,	
3-003p	rs aft rral", Exar	ed k	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🗓 No Specify:		Specify: Wh	ite
ဂ ဂ	2 hou "natu adical	plet		edent's Usual Occupation e kind of work done during most of working	ng 16	6b. Kind of Business In	dustry
7	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Alygiene do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)		Art	
	ed wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, Last)	Teacher 18. Mother's Name	(First, Middle, Ma		
yland	ld be fil Mental iarked atic ev	2	Henry Alexander Halpern	Sylvia		Rapport	
Mary	should and Me is mar raumati			iling Address (Street and Number or Rura			Code)
	サンサー		Mark Silinsky / Son 4509	Everett Street; Ke	ensington	, MD 20895	·
_			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition	position (Name of Ematory or other place)	ate 20	0c. Location - City or To	own, State
	mit. Page 1 bartment of bortant: If i injury or c		4 □ Donation 5 □ Other (Specify) Ft. Line	oln Crematory 1/20/			
Ra	permit. Page Department (Important: II any injury or once.			22. Name and Address of Facility Sin 1040 Rockville Pike			
			23a. Part 1. Wher the pise se, or complications that caused the death. Do not en		•		Approximate
	hysician/		shock, of heart failur. List only one cause on each line.		, ,		Interval Between Onset and Death Ndefinite
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	n ti	Examiner	is any, leading to immediate Due to (or as a consequence or).			7	ndefinite
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Š	endin use	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of deliv	
POX	deatr he att ed for	sici		Other (specify)		Month	Day Year
5	at the d by t etach	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did toba	cco use contribute to t	he cause of death?
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g	requi been shoul	Completed		·	24a. Was an	24b. Were auto	ppsy findings available
ပို့	e has e has age 2	dwo			autopsy	ed? death?	ompletion of cause of
I i	an: If tificat tor, pa	Be C	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 only one)	X No 1 ☐ Yes	2 LJ NO
S	ysicie is cer direct	To B	examiner? 1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ient 3 DOA Other: 4 Nursing Ho	me 5 🗓 Residend	ce 6 Other (Specifi	y)
o '	ng Ph fter th meral		27. Manner of Death 1 X Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) injury		28d. Describe how	injury occurred	
o i	tendi	Certificate:	2 Accident Investigation	M 1 🗆 Yes 2 🗆 No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 brours after death. within 24 brours after death. completed filled in by the funeral director, page 2 should be detached for use as the		4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,
ָ ב	spital nours neral	ledical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	h occured at the time, date and place, and	d due to the cause	(s) and manner as state	ed.
:	ne Ho in 24 t he Ful pletec	Med	(Check 2 Medical Examiner: On the basis of examination and/or inviously one) 3 Certifying Nurse Practioner: To the best of my knowledge				
: 	Vith Com		29b. Signature and title of certifier	29c, License number		d. Date signed (Month,	
	4		Jaurence A. Marcus		J	an. 18, 20	10
			30. Name and address of person who completed cause of death (Item 23a) (Type Lawrence D. Marcus, M.D. 10313 Ge	, ^(Print) .orgia Avenue, #207,	Silven	Spring MI	20902
	Sta	e.	31. Date filed (Month, Day, Year) AN 2 0 2010 A. Registrar's Signature	origin riverine, "201,	, savet	Spicing, in	20,02
	Registr		1 JAN 2 U 2010 /2 - A And	Cellan			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02865 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jr. January 19, Day 2010 Harrod Clarence 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 101 Beech Street Ft. Washington If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 14, 1926 1 🛛 M 2 🗆 F Months Hours 83 Washington, DC 220-16-8314 **Director** Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XXNo Prince George's Ft. Washington Maryland 1 4 1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 20744 101 Beech Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. XXYes 2 □ No 1946-1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 xxNo Specify: 3 XXWidowed 4 □ Divorced Year or Dates. 1951 Completed er than "natur , the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Welder 11 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ೭ Walker Louise Clarence Harrod Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Beech Street Ft. Washington, Maryland 20744 Elaine Aparicio / Personal Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 1/27/2010 Cheltenham, Maryland Maryland Vet. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Liçense 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) 13ch Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 perform 1 Yes 2 No Yes 2xx No 25. Was case referred to medica Division of Vital ector, 26. Place of Death (Check only one) Be examiner' Hospital 1 XXYes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5XX Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury work?
1 Yes 2 No 1 XXNatura 5 Pendina Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Hospital Medical 29a. Certifier 1 跶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nyrse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature ditle of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of death (Item 23a) (Type, Print completed cause of

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State Registrar 120

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Physician		tegistrar 1. Decedent's Name (First, Midd	le,Last)		imouto				12	2. Date of De				3. Time of Death
Medical Examine		AMEIL	STEPHON	HAYNE	ES					Month January	Day 14, 201	Year		2350 hrs
		4a. Facility Name (if not institution	on, give street and nu	imber)				ocation of	f Death			County o		
	4	5407 Water Street	6. Sex	7. Age (In yrs. la	ant hirthday)		er Marlb der 1 Year		r 24Hrs	8 Date of F		rince G		place (State or
Funeral Director		5. Social Security Number 217-68-6051				Mont			Min.		,			WIRGINIA
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any	_	10a. State 10b. County		10c. City,	Town or Loc	cation								10d. Inside City Limits
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er death with t , or items 23a r.must be not	2	11. Marital Status 1 $\overline{\mathrm{X}}$ Never Married 2 $\overline{}$ N	12. Was Dec			Nas Deced f Yes, spec				cify Yes or Nican, etc.)	10-	 Race White 		an Indian, Black,
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5-0036 led within 72 hour Hygiene. other than "natu the Medical Exan		10TH			CAR	DETA						RIVAT	Е	
filed vill Hyging of other truthe	۱ د	17. Father's Name (First, Middle LEE W. MCCOY	, Last)				1	8.Mother's AMM		First, Middle HAYNE		Surname)		
2121 ould be fil d Mental I s marked fic event,	5	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mai	ling Addres	s (Street					ty or Towr	, State,	Zip Code) 20772
MD d 2 sho lth and n 27 is numatic		AMMIE HAYNES	MCCOY/MOT	HER	139	00 FA	RNSWO	ORTH	LANE	UNIT	4106	5 UPP	ER N	MARLBORO, MI
Te, L I and Healt Fitcm	- 1	20a. Method of Disposition		20b. I	Place of Disp crematory or			netery,		Date	20c. l	ocation -	City or T	own, State
Pages Pent of ant: I		1 Burial 2 Cremation 4 Donation 5 Other S			VERDAL	E CRE	MATOI	RY	1/2	21/201	0 R	IVERD	ALE,	MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewith Department of Health and Mental Hygiewith finangarians. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once I now that the Medical Examiner must be notified at once I have a Completed by Finneral Director	Ī	21. Signature of Funeral Service	Licensee		22	2. Name an	d Address	of Facility	J.	B. JE	NKINS	S FUN	ERAI	HOME
	4	23a. Party Enter the disease, o	of maliantions that a	aused the death	Do not ente	474 I	ANDO	VER R	OAD	LANDO	VER 1	MARYI	AND	20785 Approximate Interval
Physician (failure. List only one cause	on each line.		Do not ente	i the mode	or dying,	Suci 1 as ca	ardiac or	respiratory a	irost, srio	ok, or rica		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence o	f):	•					_	_	\dashv	
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b. Box 68760, the death certificate by the attending physiched for use as the but Physician/Mag	2	IF FEMALE: (3b, Was decedent pregnant in t past 12 months?		outcome of preg pirth	nancy 2	Fetal deatl	3	Ectopic	pregnan	су	230	I. Date of Month	Da Da	ay Year
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the dec		Part II. Other significant condi	9 Oliki	L Community of the Comm	esulting in th	e underlvir	n cause ni	iven in Par	rt I	23e Did	tobacco	use contril	oute to th	ne cause of death?
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ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transmire to Be Completed by Physician Maclical.	o	examiner? 1 ✓ Yes 2 No	Hospital 1	Inpatient 2	ER/Outpation	ent 3	DOA	Other ₄	Nursing	Home 5	Reside	nce 6 🗸	Other:	Scene
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lospita hours ly fille	۱ ر	4 V Homicide 29a. Certifier 1 Continue 5	Physician: To the be	Local Stree		curred at th	e time da	te and nlad			-			
Division of Vital Records, P.O. Box 68760, with a Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfording Certification: To Be Completed by Divisional Madical Education and the control of t	2	(Check only one) 2 ✓ Medical Ex	aminer: On the basis	of examination a	nd/or investi	gation, in r	y opinion,	death occ	curred at	the time, dat	te and pla	ce, and di	ue to the	cause(s)
To with To Con	≨ -	29b Signature and title of certifi	and manner s er	stateu		2	c. License	e number	DC III	C.	29d. l	Date signe	ed (Mont	th, Day, Year)
		Thed. 1	1. King	Ita.	Kum		O.C.N	И.E.	OCIVI		Jan	uary 15	, 2010	
102	-	30. Name and address of perso				(f)			41	MD 616	24			
UCO	j	Theodore M. King, Jr	1	ant Medical E		111 F	enn Str	eet, Bal	timore	, MD 212	U1			
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State Registrar

DHMH 17 Rev 1/2001
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 02867 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ S January 19,2010^{ar} Doris Hendlev 10:55 P M Medical 4a. Facility Name (if not institution, give street and number)
4595 Wilkerson Road 4b. City, Town, or Location of Death Examiner 4c. County of Death Charles Brandywine 5. Social Security Number 8. Date of Birth (Month, Day, Sept. 26, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 M F 579-26-5458 ⁷1924 Washington, DC Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2XXXNo Maryland Brandywine Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4595 Wilkerson Road 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 X Widowed 4 Divorced "natural" Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Homemaker In Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Robert L. Sanford Margaret Ann Kernan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4595 Wilkerson Road Brandywine, Maryland 20613 Barbara Carruth / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗀 Cremation 3 🗀 Removal from State 01/28/2010 Maryland Vet. Cemetery Cheltenham, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 1. Kus 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician/ MONA Medical resulting in death) Due to (or as a consequence of) Examiner Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Thunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X XYes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completed filled in by determined Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number w 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

JAN21

POST OFFICE ND WALDORF MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ January Sallie Mae Holloway 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham 9. Birthplace (State or Foreign Country)

Edgefield.S.C. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday Funeral 1 □ M 2**X**□ F Months Days Hours (Month, Day, Year) 01/18/1927 82 Director 578-44-9736 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f 1

Yes 2 □ No Md. P.G. Capitol Heights 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ms 23a must be 20743 4804 Leroy Gorham Drive U.S.A. 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African-Yes 2 X No Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3 Divorced American Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) and Mental Hygiene. Domestic Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Henry Callaham Oueen Ann Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Page 1 and 2 shment of Health a tant: If item 27 i David Holloway, Sr./Husband 4804 Leroy Gorham Dr., Cap. Hgts., Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Maryland Nat'l.Mem.Park 01/23/10 4 Donation 5 Other (Specify) Laurel, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ON disease or condition Medical resulting in death) Examiner S uentiall, list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Ves 2 No 3 Probably 4 Winknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 N 24 hours after death. Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier MUD58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , mi) . 7500 Hanovertarkway Sui to 101A, Green beit, md. 20770 Cecil D. George

DHMH 17-Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2ÖÏO Mildred Μ. Hamilton January 9:05 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Golden Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min (Month, Day, Year) 1. 31, 1934 1 □ M 2 🛛 F Virginia Director 75 Yrs. 217-32-5648 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified 28a-f s Direct 1 Y Yes 2 ☐ No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 21702 United States 415 Lee Place items death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o 1 Never Married 2X Married þ Yes Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8 Healthcare Nurse is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Sutphin Carl E. Cook injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i 7048 Virginia Ave., Williamsport, MD 21795 <u> Lillian Mohler / Daughter</u> Important If iten any injury 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗔 Burial 2 💢 Cremation 3 🗖 Removal from State 1/12/2010 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Bronelio gene c Pnysician/ disease or condition Medical resulting in death) Due to (or as a conseque e of): [≮]Examiner obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? the a Unknown g Unknown by 1 signed by be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ per tension 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury after death. 2 Accident
3 Suicide
4 Homicide Accident Investigation the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 2010

Registrar

DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:00A M JANUARY 13 2010 CHERYL Ρ. **JOHNSON** /Medical 4c. County of Death
PRINCE GEORGE'S 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F WASHINGTON, DC 212-66-8509 1955 AUG. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nexical Expenses must be realised at 1X Yes 2 No Director PRINCE GEORGE'S BOWIE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20715 2805 FOLSOM LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. BLACK Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of the filed within 72 hours after of the filed that the filed that and Mental Hygiene. 1 XNever Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CENTER OFFICE TECH. 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **BROOKS VERA** JOHNSON ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2805 FOLSOM LANE BOWIE, MARYLAND 20715 19a. Informant's Name/Relationship (Type. Print) JOHNSON/MOTHER VERA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. NATIONAL CEMETERY 1/21/2010 LAUREL, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, in any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) . 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Natural 2 Accident (Month, Day, Year) 1 □Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

Matin 31. Date filed (Month, Day, Year) State JAN 2 1 2010 Registrar

29b. Sig

3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 MO 2. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2010 21:25 P. January 16. <u> Ieland Nathan Johnson</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours (Month, Day, 1 🕅 M 2 🗆 F **Director** 577-62-8975 61 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's 1 √ Yes 2 □ No MD Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 U.S. 4805 Salima Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married Yes 2 XXXVC Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 XNo Specify: Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Nat'l Geographics Society Offset Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lauretta Johnson Walter Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debrah A. Johnson-Spouse 4805 Salima Street, Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 1-23-10 Ft. Lincoln Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., NE, WDC 20018 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a conse y-ence of): Examiner 1 hrombosto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Anemia Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical tac Division of Vital Records, P.O. Box 68760 IE FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 No 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No မှ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Director:

Name and address of person who completed cause of death (Item 23a) (Type, Print) Pelbreton State Registrar

Medical

29a. Certifier

Signature and title of certifier

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

City or Town, State)

29d. Date signed (Month, Day, Year)

2010

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Division of Vital Records, ral or Attending Physician: The law requirers after death.	by the	cat	2 Accident		stigation	28e Place o	f Injury - At h	ome, farm, stree	t factory o				Rf Location	(Street	and Number of D	ural Route Number, (City
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- 3 -	O .	ž	29b. Signature and	title of certific	er /				29c. l	_icense r	number			29d	Date signed (Mo	onth, Day, Year)	
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1		-	30 Name and addr	ess of person	who comp	leted cause of	of death (Item	123a)			_						\dashv
γ			Carol Allan,			neted cause of	,	111 Penn S	treet Ra	altimor	e. MD 2	1201					
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LEON JOYNER 2010 4:46P JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** LEONARDTOWN ST. MARY'S HOSPITAL ST. MARY'S . Social Security Number If Under 1 Year If Under 24 Hrs. Date of Day, Ye (Month, Day, Ye 10 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Days Hours NORTH CAROLINA **Director** SEPT 229-54-2555 Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo PRINCE GEORGE'S MD LANHAM 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6915 HEIDELBURG ROAD 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 → No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 Divorced BLACK Year or Dates 27 is marked other than "natu traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE LAB TECHNICIAN 4 YRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE W. JOYNER ROSA HOWCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6915 HEIDELBURG ROAD LANHAM, MARYLAND 20706 FRANCIS J. SKINNER/SISTER permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State EDENTON, NORTH CAROLINA 1/23/2010 4 Donation 5 Other (Specify) VINE OAK CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CARDIOPULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events HYPERTONSION the attending physician and hed for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No g Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ctehast rage 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 🔣 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director; k Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 1 XNatural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IBRADO Po BOX 31. Date filed (Month, Day, Year) 32. Registrar Signature State JAN 2 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eunice M. Jameson Medical January 2010 3:30p4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary At Holy Cross Burtonsville <u>Burtonsville</u> Montgomery Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec. 25, 1 Birthplace (State or Foreign Country) Days Months 1 M 2 1 F Hours Director 472-26-3940 Minnesota Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27: is marked other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Woodbine Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3204 Hayloft Court United States 21797 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) National Sec. Agency <u>Analvst</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Motschenbacher Alice Evert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hayloft Court, Woodbine, Maryland 21797 Jameson/ Hushand Baltimore, <u>John</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Crestlawn Memorial Park 1/15/2010 Ellicott City.Maryland 21. Signalu Funeral 36 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ dvan disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on Exami ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Georgia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801

32. Registrar's Signature

Sunitha Bhogavilli MD.

31. Date filed (Month, Day, Year)

00054566

Avenue, Suite 117, Silver Spring, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year <u>7:</u>40A^M Ardis M. Watkins Jacobs <u>January</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2500 Drift Wood Court Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 477-32-0460 July 17, 1932 Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits TX⊡Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 2500 Drift Wood Court U.S.A. 21702 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leland Arthur Hanson Margaret Menge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Drift Wood Court, Lee M. Jacobs - Husband Frederick, Maryland
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda Methodist Cemetery 1/21/10 Damascus, Maryland 21. Signatur 1 of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home Loveil 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL 10 DAYS VASCULAR Accident disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be ပ

Funeral

Director

if than "natural", or items 23a or 28a-f show

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Media once.

Baltimore, Maryland 21215-0036

burial-Physician/Medical the as for use Completed

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Exami

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Be

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Certification:

Medical

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a, Certifier

attending physician signed by the a page 2 should been has certificate this After n 24 hours after death.

He Funeral Director: After the function of the functi

requires that the death certificate be executed

Box 68760,

P.0.

Records,

Division of Vital

or Attending

Hospital

5

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of investigation 6 Could not be determined

Christian

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

29c. License number 021936

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

4. DONELSON, MD 65C

UB ANSON THOMAS FREDSEICK 31. Date filed (Month, Day, Year) 32. Registra s Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT GRAASBALL JENSEN Medical JANUARY 2010 6:32 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days 099-12-9991 Director Hours Nov. 4 1927 New York Usual Residence of Decedent 28a-f show 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Thurmont 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 10505 Putman Road 21788 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 X Yes 2 ☐ No Black, White, etc. WWII "natural", If Yes, Give Year or Dates 3 Divorced 1 ☐ Yes 2 X No Specify: Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Sales Electronics Be 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ပ Jens Jensen Julie Mikkelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Scott A. Jensen / Son 7197 Adirondack Dr., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. Date7. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Crematorv 2010 Frederick, Maryland 21. Signature of Inneral Service Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease shock, or leart failure. Li mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ardiopul monary Medical Due to (or as a consequence of): Examiner HyperCopnic Respirator Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 L 9 Unknown Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate | performed Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Other: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Hospital or Attending 24 hours after death. 28d. Describe how injury occurred 1 Natural 5 Pending iniury To the Front within 24 hours after com.

To the Funeral Director: After completed filled in by the front of t 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

R+1

Box 68760

Records, P.O.

Division of Vital

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

Shoaib Ali, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 19

400 West 7th Street,

. Registra 's Signature

KNEUM

29c. License number

00068977

Frederick, MD 21701

29d. Date signed (Month, Day, Year)

Jan. 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ TOI	partment of Health and Menta ertificate of Death	Il Hygiene Reg. No. 2010 02877
Physic		Decedent's Name (First, Middle, Last) RICHARD JAMES KEELER	Moi	
/Medi Examii	ner	4a. Facility Name (If not institution, give street and number) Civista Medical Center	4b. City, Town, or Location of Death	4c. County of Death Charles
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Dave Hours Min (Mo	e of Birth nth, Day, Year) 7-1934 9. Birthplace (State or Foreign Country) MASS.
aryland show	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits 1 ☑∀es 2 ☐ No
ith the Marylan or 28a-f show	Director	MD . CHARLES 10e. Street and Number	LA PLATA 10f. Zip Code	10g. Citizen of What Country?
th wi	[a]	101 WESLEY DRIVE	20646	U.S.A.
Te, Wan y fallo ZIZISTOSSO I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Bedical Examinar roust be neithed at	by Funeral	1 Never Married 2 Married 1 Yes Cive USAF	. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, € 1 □ Yes 2 ₽ No Specify:	s or No- etc.) 14. Race - American Indian, Black, White, etc. SpecifyWHITE
72 hour 'natural'		(Specify only highest grade completed) (Giv	redent's Usual Occupation re kind of work done during most of working	16b. Kind of Business/Industry
d within ygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DRIVER	SELF EMPLOYED
Lal ylallo 212 2 should be filed within and Mental Hygiene. is marked other than aumatic event, Iha Me	To Be	17. Father's Name (First, Middle, Last) CHARLES A. KEELER	18. Mother's Name (First, MARION CL	· · · · · · · · · · · · · · · · · · ·
		1	ling Address (Street and Number or Rural Route WESLEY DRIVE LA	Number, City or Town, State, Zip Code) PLATA, MD • 20645
Pages 1 and 2 nent of Health and 1 it item 27 is nry or other training or other trai	3	20a. Method of Disposition 20b. Place of Disposition	position (Name of Date ematory or other place)	20c. Location - City or Town, State
		4 Donation 5 Other (Specify) MARYLAN	ID VETS • CEM 2-3-201 22. Name and Address of Facility	0 CHELTENHAM, MD.
permit. Departr Importa any inji	0.0	21. Signature of Feneral Service Licensee M00479	RAYMOND FUNERAL SE LA PLATA, MARYLAND	RVICE, P.A. 20646
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		atory arrest, Approximate Interval Between Onset and Death
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
The law requires that the death certific. The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as the state of th	Physician/Med		☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
quires that n signed build be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
The law requir cate has been s	Completed			a. Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 Yes 2 No
Physician: The This certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec	
ine ine	tion: To	1 Yes 2 No Postian 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time Injury 2 Accident investigation	of 28c. Injury at 28d. De	☐ Residence 6 ☐ Other (Specify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		cation (Street and Number or Rural Route Number, y or Town, State)
Hospita 24 hours Funeral etely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and du investigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifler	29c. License number	29d. Date signed (Month, Day, Year)
2121		30. Name and address of person who completed cause of death (Item 23a) (Type	1 1011	1/29/10
1,		James Harring MO201 Centern 31. Date filed (Month, Day, Year) 32. Registrar's Signature	14/5T La Plat	4 MD 20646
Sta Regist		FEB 0 3 2010 Seven 32. Registrar's Signature		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 14^{ay} 2010 4:30 RODNEY KESSLER EVANS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **QUEEN ANNE** CENTREVILLE **QUEEN ANNE COUNTY HOSPICE CENTER** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🗶M 2 🗆 F Months JULY 9, 1926 NEW JERSEY Director 83 137-20-9766 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Tes 2 No CENTREVILLE MD QUEEN ANNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21617 USA 212 QUAIL RUN DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates. 1944–1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married δ 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PUBLIC SERVICE UNIFORMED FIRE FIGHTER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MYRTLE SELMA WEBER WALTER EVANS KESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 212 QUAIL RUN DRIVE, CENTREVILLE, MD 21617 AVIS L. KESSLER/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State CHESAPEAKE CREMATORY 1-18-2010 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ CANCER PROSTATE YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year signed by the aid be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Box 68760 P.O. Records, **Division of Vital**

Maryland 21215-0036

Baltimore,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Be

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Certifical

Medical

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State

Registrar

29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at work?

D39887

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year) January 14, 2010

28f. Location (Street and Number or Rural Route Number,

1 Yes 2 No

perform

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE

28d. Describe how injury occurred

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H. Smith, MD 8221 Teal Drive, Suite 301, Easton, MD 21601

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year) JAN 15 2010

25. Was case referred to medical

5 Pending

Investigation

determined

6 Could not be

examiner?

1 Yes

Natural 2 Accident

29a. Certifier

(Check

only one)

2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

Manner of Death

Accident

32 Registrar's Signatur

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1		State of Maryland / [Department of H Certificate of D	lealth and M De <i>ath</i>	ental Hygiei Reg.		02879		
	Dharisin		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death		
	Physicia Medic	al .	Kathryn 4a. Facility Name (if not institution, give str		ng	Location of Death	January 19	4c. County of Deat	2:34 P M		
	Examin	er	Ft. Washington Hos			shington		Prince Ge	eorge's		
	Funeral Director		3/9-22-0443	M 2 KKF 7. Age (In yrs. last birth	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Yea June 26, I	9. Bird Co.	thplace (State or Foreign ^{untry)} Virginia		
	and show Lat	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town					10d. Inside City Limits		
	Maryl 28a-f otifiec	irect	Maryland Prince Geo	orge's Ft. Wa	shington				1 ☐ Yes 2 🗓 No		
	vith the 23a or st be r	Funeral Director	10e. Street and Number 8822 Oak Lane		10f. Zip Code 20744	4	10g.	. Citizen of What Co USA	ountry?		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXNo If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2XX No	n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W			
15-0	72 hou n "natu fedica	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	Decedent's Usual Occupa (Give kind of work done of life, DO NOT use retired)	ation luring most of worki	ng 16i	b. Kind of Business	Industry		
212	within giene. er thai		Elementary/Seconday (0-12) 10 years	College (1-4 or 5+)	Seamstress			Department S	Store		
and	oe filed intal Hy ced oth	To Be	17. Father's Name (First, Middle, Last) Franz Ko	ch		18. Mother's Name Bessie	First, Middle, Maid, Shultz				
ary	hould the and Me is mark		19a. Informant's Name/Relationship (Type	e, Print) 19b	o. Mailing Address (Street a				o Code)		
e, Z	and 2 s Health em 27 i		Katherine King / Dar 20a. Method of Disposition		733 Janice Lane			1 20748 c. Location - City or	Town State		
MOĽ	age 1 aent of P ent of P nt: If its		1XX Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 🖋 ☐ Other (Specify)		of Disposition (Name of ary, crematory or other place nabas Ch. Cemeto			emple Hills			
Baltimore, Maryland 21215-0036	permit. F Departm Importa any injur		21. Signature of uneral Service Licensee		22. Name and Addres		orge P. Kala on Hill, Mar	as Funeral l ryland 20	Home P.A. 745		
			23a Part Enter the disease, or complice shock, or heart failure. List only one	cations that caused the death, Do r	not enter the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between		
-	nysician/ Medical	i ii	Immediate Cause (Final disease or condition resulting in death)	CARDIAC ARR					Onset and Death		
	Examiner		CORONARY ARTERY DISEASE								
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	of):						
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
9	icate be executed physician and sthe burial-transit	edical	d	i							
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-ponths? 1 Yes AANo 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnand 5 Other (specify)	sy		23d. Date of de Month	elivery Day Year		
P.0.	that th ned by e detac	by Ph	Part II. Other significant conditions con		in the underlying cause given	ven in Part I.			o the cause of death?		
rds,	equires een sig nould b	eted	Cerebrovascu	ılar Accident		_	-		Probably XX Unknown		
Reco	The law nate has b	Completed			.,		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of		
ita	certific rector,	Be	25. Was case referred to medical examiner? 1 X Yes 2 \sum No	ospital:	Oth	ace of Death (Checker:		• E e :	<i>"</i>		
of V	ig Physicar this	te: To	27. Manner of Death		utpatient 3 □ DOA ☐ Time of 28c. Injury work	y at	me 5 Residenc 28d. Describe how i		oify)		
ion	tendin death. tor: Aff the fur	Certificate:	XX Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suiclde 6 ☐ Could not be		M 1 🗆	Yes 2 No	28f. Location (Stree	t and Number or Di	umi Pauta Numbar		
Sivis	al or At s after I Direct d in by		4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, ractory, office	,d	City or Town, S		ar noute willber,		
_	To the Hospital or Attending Physician: The law within 24 buours after death. To the Furnarial Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examina	cian: To the best of my knowledge, er: On the basis of examination and/o Practioner: To the best of my know	or investigation, in my opinio	on, death occurred at	the time, date and p	place, and due to the	cause(s) and manner stated.		
	To the within 2 To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Tractioner: To trie best of my know	29c. Licens	e number	29d	. Date signed (Mon	th, Day, Year)		
	10		Clefral for	m/		300 DC		January 20,	2010		
	2		30. Name and address of person who co Alfred C. Burris MD	1328 Southern Ave	enue S.E. Washi	ngton, D.C.					
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 2010	32. Registrar's Signature	es e						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of M 1 - Statemended#26perMD FCHD KS Registrar	aryland / De	epartment of Hea Certificate of Dea	alth and M ath	ental Hyg	iene 20 I	0 02880
			Decedent's Name (First, Middle, Last)				2. Date of Deat	:h	3. Time of Death
	Physicia Medio		MICHAEL	KEENE	Y		Month JANUARY		2:44P M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of I	Death
- 1			FREDERICK MEMORIAL FREDER		FREDERICE			FREDE	
	Funeral Director		213-80-2016 1 X M 2 □ F	e (In yrs. last birthda 51 Yrs	Months Days H	Under 24 Hrs. Iours Min.	8. Date of Birth (Month, Day 01/19/	1958 N	. Birthplace (State or Foreign Country) Iary Land
	nd how at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits
	laryla 3a-f s ified	Director	MD Frederick	Frederi	ok				1 √2 Yes 2 □ No
	or 26 e not	ij	10e. Street and Number	rreueri	10f. Zip Code			10g. Citizen of Wha	AL .
	with s 23a ust b	Funeral	309 Willow Avenue		21701			United St	tates
	item:		11. Marital Status 12. Was Decedent Armed Forces?	ever in U.S.	13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec	ify Yes or No-		American Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	ed by	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.		1 ☐ Yes 2 🎇 No S		ican, etc.,	Specify: V	Vhite, etc. Vhite
5-0	2 hou "natu	Completed	15. Decedent's Education (Specify only highest grade completed)		ecedent's Usual Occupation ive kind of work done during		a I	16b. Kind of Busin	ess Industry
121	thin 7	ĕ	Elementary/Seconday (0-12) College (1-4 or	5+) life	e. DO NOT use retired)	•			
i D	Hygie Hygie other ont, th	Be C	17. Father's Name (First, Middle, Last)	<u> </u>	rniture Rest	oration Mother's Name	/Eimt Middle A	Antique	9
auc	be file ental I ked o c eve	일	Charles L. Keeney			Grace Ri		raideri Surriarrie)	
37	12 should balth and Me 27 is mark r traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. N	lailing Address (Street and I			City or Town, State	a. Zip Code)
ž	d2shaltha altha 27is ertra		Connie Keeney (wife)		Willow Ave.				, -,,
ore,	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		isposition (Name of crematory or other place)	D	ate	20c. Location - Cit	y or Town, State
Ĕ	Page ment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		own Cemetery	01/16	/2010	Lewistown	n, Maryland
Baltimore, Maryland	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee	bosts	22. Name and Address of 1621 Opossum				
			23a. Part 1. Enter the disease, or complications that cause	the death. Do not					Approximate
	nysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Ponenta	Cardiovas	rates)	Die		Interval Between Onset and Death
	Medical Examiner		regulting in death)	a consequence of):	- William	CITOLO	100		To the second
	LXdiffiller	je je	Sequentially list conditions, b.						<u>'</u>
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a curisequence of):					
	xecut n and al-trar	Exa	that initiated events C.	a consequence of):					
09	s be e	dical	d						
376	fficate ig phy as the		IT FEMALE.						
۵۵ ×	n cert tendin r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome		3 Ectopic pregnancy			23d. Date o	
P.O. Box 687	To the Hospital or Attending Physician; The law requires that the death certificate be executed within £4 hours are death. To the Funeral alrector Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 Other (specify)			Month	Day Year
Ö.	hat the	y Ph	Part II. Other significant conditions contributing to death b	out not resulting in the	ne underlying cause given ir	in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
S,	uires t n sign lid be	q pe					1 🗆 Ye	es 2 No 3[☐ Probably 4 ☐ Unknown
000	w requ	plet					24a. Was ar		e autopsy findings available
Sec.	he lar	mo					autops perform	med2 deat	r to completion of cause of th? Yes 2 \(\square\) No
a	ian; T irtifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place o	of Death (Check		Z NOT	100 2 2 100
5	hysic his ce il dire	뎯	1 ☐ Yes 2 No Hospital: 1 ☐ Inpat	ient 2 K ER/Outpa		4 Nursing Hon	ne 5 Reside	nce 6 ☐ Other (S	Specify)
Division of Vital Records,	ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 Accident Investigation 28a. Date of inju (Month, Da		ry work?		d. Describe ho	w injury occurred	
Sion	death ctor y the	tific	3 Suicide 6 Could not be	ury - At home, farm	M 1 ☐ Yes	2 🗆 No	8f Location (Str	reet and Number o	r Rural Route Number.
E S	alor/ saler il Dire		4 Homicide determined building, et		,		City or Town		, , , , , , , , , , , , , , , , , , , ,
_	lospit 4 hour unera ed fille	Medical	29a. Certifier (Check Medical Examiner: On the best of	my knowledge, dea	ath occured at the time, date	te and place, and	due to the caus	se(s) and manner a	s stated.
	the L	Me	only one) 3 Certifying Nurse Practioner: To the	best of my knowled	ge, death occurred at the time	ne, date and place	, and due to the	cause(s) and manne	er as stated.
	5.≱ 6 8		29b. Signature apartitle or certifier	14-1	29c. License nun	-/397		9d. Date signed (M	onth, Day, Year)
	. 6		30. Name and address of person who complete cause of c	leath (Item 23a) /Tim		,017		1/13/	10
	10		Robert L. Kaufmann 300 W.		eet Frederick	k, Maryl	and 217	01	
	Stat		- (日本) (1 - (1 - 2) (ar's Signature	1 1	**			
	Registra	ar	GHIL TO SOLO TO	nervis B	. Sparked				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 9:15 A Lewis R. Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Huspice at 1.55ur Conico the 8. Date of Birth
(Month, Day, Year)
6-17-1919 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 🏻 F Months Director 90 219-05-0535 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 ☐ Yes 2X No Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 21849 IISA 32737 Mt. Hermon Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Medica1 12 Secretary is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 32737 Mt. Hermon Road, Parsonsburg, Maryland 21849 Sharon Adkins - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Buckingham Cemetery 1-18-2010 Berlin, Maryland 21. Stature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause by each line. shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ CERRBROVAS ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine day, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2/5 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 27 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2/EFRo 1 ☐ Yes 2 ☐ 🛱 Be 25. Was case referred to medical 26. Place of Death (Check only one) 24ERIO Other: 4 Nursing Home 5 Residence Other (Specify) ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director, completed filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

မ

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAM

30

Registrar's Signat

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3) SAUSBURY

29d. Date signed (Month, Day, Year)

21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 2030 Stephanie Rose Lesney January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bethesda Suburban Hospital Montgomery 9. Birthplace (State or Foreign Country) Michigan Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days (Month, Day, Year au 18, 1 Months Hours Min Director 86 384-14-6704 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Rockville 1 Tes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10301 Grosvenor Place. 20852 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Computers Supervisor Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any lijury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Antoni Obelnicki Mary Cwiankala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Lesney - Son 124 N. Windwood Heights, Cabot, Arkansas 72023 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Florida National Cem. 01/21/2010 | Bushnell. Florida 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. amo (11800 New Hampshire Ave., Silver Spring, MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part 1. Enter the dise Approximate Interval Between Onset and Death 3 ULOUS shock, or heart failure. Li Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Cancer uears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and -trans that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect physician at the burial-t resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🗓 No Month Pregnant at time of death Dav Year 1 Yes 2 2 9 Unknown 9 Unknown this certificate has been signed by rail director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No Yes 2 X No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Yes 2 X No Other: |요 1 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending e nost... n 24 hours after deau... he Funeral Director: Aft ☐ Accident ☐ Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practionars to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier è 29c. License number Haggerly Joseph on. 10 D32407 January 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9707 Medical Center Drive, Rockville, Maryland 20850 Joseph M. Haggerty, 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna Elizabeth Lombre January 20°10 18 05:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Habour Health & Rehab. Cente Anne Arundel Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 0*8%*62*9*4**92**9 Washington, D.C. Director 379-09-8460 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 20906 United States 14514 Homecrest Road, Apt. L-27 items hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? Black, White, etc. ŏ þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify. "natural", 3 X Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than "r
r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawyer Whiting Eva Dodson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4933 Bonniewood Drive, Shady Side, Maryland 20764 Shelita A. Fanciulli/Daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 $\stackrel{\longleftarrow}{X}$ Cremation 3 \square Removal from State 01/19/2010 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F 22. Name and Address of Facility George P. Kalas Funeral Home 973 Solomons Island Road, Edgewater, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rune 10 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🙀 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 X Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Menner of Death 1 🖺 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a, Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D57028 January 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Aditya Chopra, 600 Ridgely Avenue, Suite 231, Annapolis, Maryland 21401 1 9 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State

DHMH 17 Rev 1/2001

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Registrar

31. Date filed (Month, Day, Year)

6 Post office Rd. Woldorf, md. RAVI SINDHWANI, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Physician/ 00/8 AM Jeanne Marie Moulaison Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner KOW 8. Date of Birth 10/21/1928 Birthplace (State or Foreign Country) . Age (In yrs. last birthday **Funeral** Months 013-22-9997 81 MA Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hyglene. Hant If I flear 27 is marked other than "natural", or items 23a or 28a-f should not other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo Ocean Pines MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 108 Watertown Rd. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 X Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Life Insurance Co. Computer Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lugene Moulaison Philomena Bourque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 Ocean Parkway Unit 218 Berlin, MD 21811 Irene Marie Menghi / sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Donation 5 Other (Specify) Woodlawn Memorial Pk:1/23/2010 Georgetown, DE 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause of Onset and Death Immediate Cause (Final VALVE STENOSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnan ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 21 No မ 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 2 No M 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 746536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

BA 8

m.D.

Carrollst. Salsbury. MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of IVIA State Registrar	,	ertificate of			g. No. 2 () (02886
	Physicia	an	1. Decedent's Name (First, Middle, Last) Ervin Coley Marsh, Jr.				Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	JANUARY	19 2010 4c. County of Dea	
-	Examin	er	Berlin Nursing & Rehab. Ce	nter	Berlin			Worcester	•
	Funeral Director		5. Social Security Number 214-30-9072 Usual Residence of Decedent	78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7/11/19	Ye <i>ar)</i> 9. Bir Co	thplace (State or Foreign ountry)
	yland Now		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	a-fsk	ctor	MD Worcester	0cear	Pines				1 ☐ Yes 2 🖾 No
	vith th	Dire	10e. Street and Number		10f. Zip Code	1	10	g. Citizen of What Co	ountry?
	ns 23	Funeral Director	81 Battersea Rd. 11. Marital Status 12. Was Decedent E	Ever in U.S. 1	2181 3. Was Decedent of H If Yes, specify Cub		ecify Yes or No-	USA 14. Race - Ame	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evant her must be nuffled at	þ	1 ☐ Never Married 2 ★ Married 1 ★ Married 2 ★ Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	lo	If Yes, specify Cub 1 ☐ Yes 2 No	an', Mexican', Puerto Specify:	Rican, etc.)	Black, Whit	
2-0	"natul	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De (Gi	cedent's Usual Occup ive kind of work done b. DO NOT use retire	oation during most of work	ina	6b. Kind of Business	Andustry State Board
7	within iene. • than	omp	Elementary/Secondary (0-12) College (1-4or 5-	+)	cational i			of Educati	
bu	e filed al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M.		
<u>yla</u>	ould be i Mental larked o	To	Ervin Coley Marsh, Sr.			Louella I			
Mar	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Merle M. Marsh	/ /	ailing Address (Street Battersea				
ē,	s 1 and f Heal ftem 2 other		20a. Method of Disposition		sposition (Name of rematory or other pla			oc. Location - City or	
m 0	Pages ment of ant: If its arry or o		1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ilopen Crei	i	/2010	Frankford	I, DE
3alti	permit. Page Department of Important: If any injury or once.		21. Signat re Juneral Service Licensee		22. Name and Addre	ess of Facility Bu	rbage Fur	neral Home	
			23a. Part . Enter the disease, or complications that caused	the death. Do not	108 Willi				Approximate
	Physician		shock, or heart failure. List only one cause on each lin Immediate Cause (Final	ie.	ilure	ng, odor do odraido	or roophatory arro-	04,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	a concessioned off:					
	Examiner		Samuel Melly Bet conditions b. Mctas		relanossa	9			
	ted sit	Examiner	aguas Enter Underlying	a consequence of): んれいかん・					
<u> </u>	tificate be executed g physician and as the burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a	a consequence of):					
68760,	ate be nysicia he bur	edical	d						
89 ×	ertifica ding ph		IF FEMALE:			7.5			
P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of de Month	Day Year
ر. ص	s that med b	y Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the	e underlying cause gi	ven in Part I.	23e. Did tob		o the cause of death?
ğ	equire sen siç ould b	ted k	Atrial fibrillation				1 ☐ Yes	s 2 No 3 ☐ F	robably 4 Unknown
Division of Vital Records,	The law r cate has be page 2 sh	Completed by					24a. Was an autopsy perform 1 🗆 Yes 2	prior to	utopsy findings available completion of cause of s 2 □ No
<u> </u>	siclan certifi rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	4 AFFR/2 4	tions of post Oti		h (Check only one		<u> </u>
ō	g Physer this eral di	n:To	27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpa	e of 28c. Inju	ary at	28d. Describe how	nce 6 Other (Sp. w injury occurred	ecify)
ion	ending rath. or: Aftunhe fun	atio	1 Natural 5 □ Pending (Month, Dag 2 □ Accident investigation	y, <i>Year)</i> Injur		Yes 2□No			
Divis	al or Atto s after de al Directo ed in by t	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc	ury - At home, farm, c. <i>(Spe</i> c <i>ify)</i>	street, factory, office		28f. Location (Str City or Town,	eet and Number or F , State)	lural Route Number,
	he Hospit in 24 hour he Funer: pletely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/o	r investigation, in my	opinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
	70 t With 70 t	Σ	29b. Signature and title of certifier Madraal	vet sor (se number 9 25 7		Od. Date signed (Mon	
			30. Name and address of person who completed cause of d	eath (Item 23a) (Typ	pe, Print)			011.1120	
B	A10+1		Claudia D. Arumala 9715 1	Hearlt was		Beria, ma	21811		
#?	Sta Registr		31. Date filed (Month, Day, Year) 32. Registr. JAN 2 0 2010	ar's Signature	1				

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Celia 6:35 pM Mizgerd January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sanctuary at Holy Cross Montgomery Burtonsville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Months Days Hours April 26, 1 M 2 94 1915 New York 161-05-0242 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 28a-f 1 Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** items 23a 718 Auburn Avenue 20912 USA hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ö δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. "natural", Specify: 3 X Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of ပ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked Andrew Figura Barbara Varga other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucyanne Hurley/Daughter 4008 Hillwood Court, Beltsville, MD 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 🗷 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) etery, crematory or other place) 18, injury or St. Andrew's Cemetery 2010 North Catasaugua, PA Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Yes 2 X No ed by the a detached f 9 Unknown P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2: autopsy performed Yes 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) ပ္ D54566 Jan. 14, 2010

State Registrar . Registrar's Signature

9801 Georgia Avenue, #1-17, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunitha Bhogavilli, MD

15

2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death - 15 - 3010 Physician/ Month Year Lillian Alaine Maddox 3:10 AM Oi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Coastal the Salisbury Wicomico Hospice at If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Country) Days Hours Month, I Sept 9 219-05-3001 86 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Y Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 508 Village Court 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. African Specify: 3 XWidowed 4 ☐ Divorced American 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Caretaker 12 Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Hearn Viola Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Fletcher/daughter 29723 Jackson Road, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Springhill 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2010 Hebron, MD Memory Gardens 21. Signature of Fineral Service Licensee Name and Address of Facility
 Lewis N. Watson Funeral Home, PA
 1618 West Road, Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, PANCRRATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 pronths? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/1 No 1 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Pother (Specify) HOSP (GZ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

[2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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WARK

JAN 20 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:30 pm Maria Olga Mychajliw January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Rockville Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Ukraine **Funeral** Months Days Hours 02 Month, Pay, Year) 1 □ M 2 🗓 F Director 93 058-26-5125 Usual Residence of Decedent show 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director 1 ☐ Yes 2 🗓 No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 20853 13501 Dowlais Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Caucasian Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Primary School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Lasota Michael Bojdunyk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13501 Dowlais Drive. Rockville, Maryland 20853 Roman Mychailiw - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Andrew Ukrainian
Cemetery 🗓 Burial 2 🗆 Cremation 3 🗓 Removal from State 01/21/2010 S. Boundbrook, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. naure o Funera S rvice Licensee M00709 11800 New Hampshire Ave. Silver Spring. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Heart Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Chronic Obstructive Pulmonary Disease attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 X No Dav 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Dementia 1 Yes 2 No 3 Probably 4 X Unknown cate has been sig page 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 🗶 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital or Attending Physician: The To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I Division of Vital

State

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hours

Thomas V. Joseph,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

M.D.

37. Registrar's Signature

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0047330

50 W. Edmonston Drive, Suite 207, Rockville, MD 20852

29d. Date signed (Month, Day, Year)

January 19, 2010

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH G900 2/19/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Orian Manuel Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death ninsula Regional Med cal conto 8. Date of Birth 10/17/1926 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Vîrginia 83 Hours Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Pittsville Maryland 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21850 34878 Old Ocean city Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc þ 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates. Army white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eliza Landen Orian T. Manuel 19a. Informant's Name/Relationship (Type, Print)

Irmgard Manuel/spouse 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zin Code) 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2010 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 an Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Sep515 disease or condition Medical resulting in death) Due to (or as a consequence of) difficille colitis Examiner OSCTI NUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ned by the atter in the past 12 months? Month Yes 2 No Division of Vital Records, P.O. s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) HO059368 2010 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrell ST Salishory MD

DHMH 17 Rev 7/2009

State Registrar

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OU E. egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02891 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ERNEST Physician/ MILLER Month ZO O 035U M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 921 Madison Street Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214-05-0410 1 Ø M 2 □ F 97 (Month, Day, Year) une 5, 1912 Director Yrs June Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Maryland 1 XYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 921 Madison Street 21403 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Mechanic Lumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Peter Miller Barbara Heckel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Annamolis Maryland 21401 19a. Informant's Name/Relationship (Type, Print)
Gertrude Miller/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 1/20/2010 Annapolis, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis,MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2. No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my prowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Date signed (Month, Day, Year,

State Registrar

31. Date filed (Month

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

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on who completed cause of death (Item 23a) (Typ

ENTAM

ENSE HIGHWAY ANN APULIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MULLIGAN Physician/ 0830M 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ I Days b2%18/1933 Washington,D.C. Director 579-44-9717 74 Usual Residence of Decedent should be filed within 72 hours and had Mental Hygiene.
All is marked other than "natural", or items 23a or 28a-f show 27 is marked other than "dadical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9104 3rd Street 20706 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1952-54 1 ☐ Yes 2 √ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Mechanic Elevator Installation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Louis Mulligan Lorretta V. Quinn other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Merrijeanne Mulligan/Wife 9104 3rd Street, Lanham, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify)

21. Signatury by Angel Serving Licensed Maryland Veterans Cemetery 101/22/2010 | Crownsville, Maryland Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day signed by the a d be detached f g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, as been signal 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate; 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1—certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Sian re and title of certifie ٥ 29c. License numbe ed cause of death (Item 23a) (Type Name and address of person who o W /32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12, 2010 Clifford L. Mustion January 2:46 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Laurel Regional Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 493-40-6554 Director May 21, Oregon 70 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Show r than "natural", or items 23a or 28a-f showing the Wedest Examiner must be notified at 1 ☐ Yes 2X No Director Laurel Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1B Rose Street 20724 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No IfYes, Give Year or Dates:1956-57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White 3 ☐ Widowed 4 ♥ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Antiques Dealer Antiques 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental Woody Mustion Anita June Atkinson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health as Important: If item 27 is any injury or other trau Carla J. Carter/ Daughter 1516 Manor View Rd., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 🗆 Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1/14/10 Edgewater, Maryland 21. Signature of frate enice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Wille 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Box 68760 requires that the death certificate be Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Arteriosclerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed After this certificate of Vital 1∐Yes 21√2No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation ours after death.

neral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical

brl 10

State Registrar

29b. Signature and title of certifier

Thomas H. Burguieres, M.D. 7300 Van Dusen Road, Laurel, MD 20707 Registrar's Signature

eva

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

022966

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Alice Ingersoll Nagle 18, 2010 January 10:05 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase 7012 Bybrook Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 213-48-5338 Director 87 04/26/1922 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show 1 ☐ Yes 2 ☑ No MD Montgomery Funeral Director Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7012 Bybrook Lane 20815 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? and 2 should be filed within 72 hours after 1 ∐Yes 2 ∏ If Yes, Give Year or Dates: 2 🔯 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2 No Specify: Specify: White λq "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H Be Royal E. Ingersoll ည Louise Van Harlingen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600Royal E. Ingersoll / Nephew #722 Arlington, VA 22209 North Oak St 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 01/20/2010 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident (Stroke) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending

Box 68760, P.O. Division of Vital Records, Hospital or Attending Physician: after death.

I Director: After din by the fur

To the Hosp within 24 hor To the Fune completely fi

State

Registrar

Medical

29b. Signature apolitile of certifier

29c. License number

D29353

1 ☐Yes 2 ☐ No

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

01/18/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation

determined

6 Could not be

George W. Graves MD 5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) JAN 2 0 2010

3 Suicide

29a. Certifier

4 Homicide



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PII, per State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joseph W. JAnner Nolan 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner cheve If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Dec • 10 Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 🖾 M 2 🗆 F Hours 73 Dec. 577-50-8152 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1X Yes 2 □ No Maryland | Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 4707 Leroy Gorham Drive United States death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 72 hours after ð 1 Yes 2 X No Maryland 21215-0036 Specify: Black If Yes, Give 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any oinee. Elementary/Seconday (0-12) 7th College (1-4 or 5+) Cemetary Grounds Keeper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys E. Price Joseph W. Nolan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl E. Baylor/ Sister 3523 Dunlap Street Temple Hills, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, January 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ☐ Donation 5 ☐ Other (Specify) 01ivet 2010 Washington, DC Stewart Funeral Home, Inc. 21. Sonature of Funeral Service License Name and Address of Facility 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ AtheroscheroTic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if a y, leading to in mediate cause. Enter Underlying Examine Dan to (unas a consequence of) burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical The law requires that the death certificate be 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic alcoholism Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 06/ State Registrar

Baltimore, Maryland 21215-0036

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		Registrar 1. Decedent's Name (First, Middle, Last)	06	Tillicate of D	Call	2. Date of Death	No. 2010	3 Jime of Death
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Funeral		5. Social Security Number 6. Sex 7. Ad	ge (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign ountry)
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ms 2:	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-	14. Race - Ame	erican Indian,
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medisal Examinat rust be notified at	by Fur	Armed Forces* 1 □ Never Married 2 ☑ Married 1 □ Yes 3 □ If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	No	If Yes, specify Cubar 1 ☐ Yes ¾▼No	Specify:	Rican, etc.)	Black, White	white
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nutified at once.		19a. Informant's Name/Relationship (Type. Print) Alfred Patrick Nelka Spo		ing Address <i>(Street al</i> Dicus Mill			ity or Town, State, Le,MD 211	
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To the within To the compl	Me	29b. Signature and title of certifier	Acus	29c. License	number	290	Date signed (Moni	th, Day, Year)
		30 A Name and address of person who completed cause of	death (Item 23a) (Type,	Print	1770		mary	1-,200
50		MICHMA JILAKENT	rar's Signature	(DEFE	NSEHTI	6 HWAy A	NAPOLIS	M/)21401
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a grap ^{te}	Funeral		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)		1 Year If U	nder 24 Hrs.	8. Date of Birth		9. Birthpl	lace (State or Foreign
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Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The man should be filed with an "natural" or items 23a or 28a-f show other traumatic event, the "hedical Examiner must be notified at		19a. Informant's Name/Relationship (•	•		al Route Number,	-		
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alti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licer		Ga	rdens (Name an	Address of I	Facility	10 Fac			
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	10		30. Name and address of person who					n .	0.1	200 5	1. , 4 4	1 - 300	20050
		•	Marcia Goldmark 31. Date filed (Month, Day, Year)		15020 Registrar's Sign		Grove	Koad,	Suite	300, Ro	CKV111	.e, MD	20830
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DHMH 17 Rev 1/2001

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AMEND ITEM#17perFH, G901, 3/25/2010, WS

State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 02898 1 - State Registra/MEND#4b+29aperMD, 1/27/10, BMW/MOCO Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rose M. A. Osunga 9:15a M 6, 2010 Medical January 4b. City, Town, or Location of Death Rockville 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** Hospital Gaithersburg Shady Grove Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year) 1948 Hours 1 □ M 2 🔀 F Min. Country) Kenya **61** Yrs Director None Sept. Usual Residence of Decedent show 10a. State 10b. County marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg M D Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20879 9309 Taverney Kenya Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry uld be filed within Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First Middle Last)
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1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No To the Hospital or Attending Physician; 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; X Natural ithin 24 hours after death.

the Funeral Director; After ompleted filled in by the fun 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) DOO 680 80 dreso MD Jan. 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Sireesha Jalli MD</u> 9901 Medical Center Dr. Rockville, Md 31. Date filed (Month, Day, Year) 2. Registrar's Signature State backer JAN 15 2010 Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

	For	Please	State of M		d / Depa	artment	of Health	and N	=		_	
	1 - State Registrar				Cei	rtificate	of Death	7		Reg. No	<u> 2010</u>	02899
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Examiner			ive street and number)				own, or Location				County of Dea	
	5. Social Security N			no (In uro I	ast birthday)	Che	evy Chas	s e er 24 Hrs.	9 Date of Bir		Montgome	
Funeral Director	577-09-00	028	1 ☐ M 2 🖾 F	95	Yrs.		Days Hours		8. Date of Bir (Month, Di Feb.10	, 19	14 Was	thplace (State or Foreign ountry) shington, DC
and	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
Mary f sh	MD	Montg	nmerv	Ch	evy Ch	ase						1 ☑ Yes 2 ☐ No
vurs after death with the Marylan ral", or items 23a or 28a-f show Examiner must be redified at 1 by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Co									ountry?		
h with	7714 Cur	tis Stre	et				20815				U.S.A.	
death death	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \	Was Deceder	nt of Hispanic O y Cuban, Mexica	origin? (Sp	ecify Yes or No	D-	14. Race - Ame	
or its		ied 2□ Married	1 ☐ Yes 2 ☑	No		il les, specili 1 ∐Yes 2∑			riicari, etc.)		Black, Whit	
ural", o	3 🖾 Widowed	4 Divorced	Year or Dates:									nite
filed within 72 hours after death with the Maryland Hygiene. Hygiene. State than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at e. Completed by Furneral Director	(Spec	15. Decedent's I cify only highest g	Education rade completed)		16a. Deced	dent's Usual kind of work	Occupation done during mo retired)	st of work	ing	16b. h	Kind of Business	/Industry
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Hygin Hygin ther ant, III	12 17. Father's Name	(First, Middle, Las	et)		пош	ie Make		her's Nam	e (First, Middle			
uld be fill Mental H arked ott attic even			,						enita H		,	
shoul nd M	19a. Informant's Na		(Type. Print)		19b. Mailir	ng Address (S	Street and Numi				or Town, State,	Zip Code)
nd 2 alth a 27 is 27 is r trau	Kathleen	Hannan/	Daughter		5212	45th	St., N.	W. W	ashingt	on.	D.C. 20	015
s 1 a of Hei	20a. Method of Dis	•			lace of Dispo	sition (Name	of er place)	Ī	Date		ocation - City or	
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mit. partn porta y Inju	21. Signature of						Address of Facil	lity De		era.	1 Home	THE 111D
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	23a. Part 1. Enter t shock, or hea	he disease, or con	nplications that caused y one cause on each li	d the death	. Do not ent	er the mode	of dying, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Between
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hat the death certificate ed by the attending physi letached for use as the l Physician/Medica			u									
endin use	IF FEMALE: 23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	ananov				23d. Date of de	livery
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic	29a. Certifier (Check only one)		Physician: To the best iminer: On the basis of and manner st	of examinat								
Vithin Vithin Comp	29b. Signature and	title of certifier	11-	1.		29c. I	License number			29d. Da	ate signed (Moni	th, Day, Year)
10	K	erno	o Wea	NON		1	MD D2312	27		Jan	uary 19.	2010
•	30. Name and addr	ess of person who	completed cause of c	,		Print)						
		. Nealon		1 01		-	ve. #140	00, C	hevy Ch	nase	,Md. 208	315
State Registrar	31. Date filed (Mon	n, Day, Year) N 2 0 20	10 Cerus	a a aignar	par	RI						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar					and M	lental Hy	giene	€			
			Registrar 1. Decedent's Name (First, Middle	. Last)		Cer	tificate	OTD	eatn		2. Date of De	Reg. No	201	0	02	<u>900</u>
	Physicia Medic		Soon	Im	Oh						Month Januar		9, 201	ar O	9:15	Δ M
	Examin		4a. Facility Name (if not institution		4b. City,	Town, or	Location c	of Death	0 011 001		County of E		7.10	Λ		
100			Ft. Washington Ho		7. 4. 4.				ningto				Prince			
	Funeral Director		5. Social Security Number 214–33–3120	6. Sex 1 ☐ M 2 XX F	7. Age (In yrs. I	last birthday) Yrs.	If Under Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir Dec 20	th ' ^{y,} Year 's	9. S		ace (State Korea	o <i>r Forei</i> gn
			Usual Residence of Decedent								200.	, 100		Juan	ROICA	
	yland -f sho ed at	ctor	10a. State 10b. County			ty, Town or Lo	cation							10	d. Inside C	•
	e Mar r 28a- notifi	Dire	Maryland 10e. Street and Number		Bal	ltimore	10f, Zip	Codo				10 0				s 2 🗆 No
	vith th	Funeral Director	1600 West Mount F	Royal Avenue				21217	7			-	itizen of What uth Kore		yι	
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	12 shouth and the sho		Myoung Ouk Kim / I				-				Route Numbe Marylar	. ,	r <i>10wn,</i> State, 20735	Zip Co	ide)	
re,	1 and of Hea item		20a. Method of Disposition			Place of Dispo	sition (Nam	e of			ate		ocation - City	or Tow	n, State	
<u>ii</u>	Page ment of ant: If ury or		1 ☐ Burial 2XX Cremation 4 ☐ Donation 5 ☐ Other (S			alas Cren		ner place		01/20,	/2010	Edg	gewater,	Man	yland	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.		21. Signature of Funeral Service I	icensee	•	22	. Name and	d Address	of Facility Hill	y Geo Road	orge P. K Oxon Hil	alas 1, M	Funeral aryland		ne P.A. 0745	•
			23a. P 1. Enter the disease, or shock, or heart failure. List of			th. Do not ente	er the mode	of dying	, such as o	cardiac o	r respiratory an	rest,			Approxima Interval Be	
um	Physician/		Immediate Cause (Final disease or condition	,	REBROVA	SCULAR	ACCI	DENT							Onset and	
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Sequentially list conditions, if any, leading to immediate HYPERTENSION Due to (or as a consequence of):																
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Division of Vital Records,	aw req as bee 2 shoi	plet									24a. Was		24b. Were	autops	sy findings	available
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ital	s ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor	ce of Deat	h (Check	only one)					
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	To the withing to the composite of the c	2	29b. Signature and title of certifier	_		y miorica ge, a		License		ara plase			te signed (Mo			
			10 44	lil -	C				D 547	723		J	anuary	19	, 201	.0
R	14		30. Name and address of person was Hengameh N. Mesbal	ni, MD 11	1711 Livi	ngston R		. Wasl	hingto	n, Ma	ryland :	20744	+			
	Stat Registra	te ar	31. Date filed (Month, Day, Year) JAN 2 1 2010	Server 32. R	egis ar's Signa	Teles .										

10-00419 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-For State ME, QACHD, 1/19/10 Certificate of Death Mary Ellen Palck Reg. No. 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Medical Examine MARY ELLEN PALEK January 14, 2010 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 9021 Legion DiRoad Dentor 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Min Director 2 X F 217-50-7468 61 1 M Usual Residence of Decedent 10a. State 10c. City, Town or Location any 10b Count 23a or 28a-f show notified at once, CAROLINE DENTON MARYLAND 72 hours after death with the Maryland Director 10e, Street and Number 10f. Zip Code 9021 LEGION ROAD 21629 Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married Yes 2 No specify If Yes, Give Year 3 Widowed 4 Divorced Yes 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other thon BOOKKEEPER 1 17 Father's Name (First Middle Last) fraumatic event, a THOMAS ANDREW PALEK MARY A. PIASKOWSKI ဥ 19a. Informant's Name/Relationship (Type, Print) MD MARY A. PALEK/MOTHER 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date CHESAPEARE CREMATION Burial 2 X Cremation 3 Removal from State JAN. 16 2010 CENTER Donation 5 Other Specify 21. Signature of Funeral Service Licenses **Physician** failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. ner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and hysician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760. IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> ے 24a. Was an autopsy has performed? ✓ Yes 2 No

2110 hrs 4c. County of Death Caroline 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or PENNSYLVANIA APRIL 27,1948 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? UNITED STATES 14. Race - American Indian, Black, White, etc. WHITE Specify 16b. Kind of Business/Industry ACCOUNTING 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 CENTREVILLE ROAD, CENTREVILLE, MD 21617 20c. Location - City or Town, State STEVENSVILLE, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Retween Onset and Death The law requires that the death certificate be executed 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Vital To the Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 Other:4 Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28c. Injury at Work? o After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 V Natural 1 Yes 2 No Director: I in by the f Pending 24 hours after death. Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined To the Funeral Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 15, 2010 30. Name and address of person who compreted cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Begistrar's Signature Registrar

ORÍGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Figure 1 Pag Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MICHAEL **PAPADOPOULOS Physician** 2010 12:06 PM Michael Papadopoulis January 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6309 Riverdale Road Riverdale Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Year! Hours 1 ▼M 2 □ F Director 219-68-4842 66 JAN. 1944 GRÉECE 1, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Morter Exeminent matter te nordificula. 1 Yes 2 □ No Directo MD. PRINCE GEORGES RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6309 RIVERDALE RD. U.S.A. 20737 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK. permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev JOHN PAPADOPOULOS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARTHENA RAMOS/DAUGHTER 12426 DEWEY RD., SILVER SPRING, MD. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY JAN.14,2010 RIVERDALE, MD. 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 21. Signature of Funeral Service License 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASYMTOMATIC CARDIO-VAS COILAR DUEASY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TON HY PER TENS Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-transit MELLITUS ABETESE and Due to (or as a consequence of) Box 68760. attending physician for use as the buria PERCHOL ESTEROLE MIX Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 ANTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 □Yes 2 No 1 ☐Yes 2 ☐No Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 9 Aesidence 6 Other (Specify) ¥ZiYes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: Afte completely filled in First 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical (Check only one)

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 831 ONIVERSITY

Registrar's Signature

Clu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

BOI,

29c. License number 2089

BLUD. RAST SILVER SPRING MD2090

State Registrar

Debra K. 31. Date filed (Month, Day, Year)

JAN 19

- PANTE MOUNDE

169-15

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101

Annapolis, MD 21401

Hardy-Cartwright 2003 Medical Pkwy

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PETER SON OSEPH A M Januar 2010 1:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 528-42-5727 73 5/23/1936 UTAH Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Director Anne Arundel Crownsville 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 557 Sanctuary Lane 21032 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🔀 No White Specify ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Computer Consultant Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence A. Peterson Lenora Meikle ္ဝ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Delgado Spouse 557 Sanctuary Lane Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 1/15/2010 Glen Burnie, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 3 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final pancreatic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 🗌 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Could not be determined 3 Suicide

law requires that the death certificate be executed Box 68760,

attending physician for use as P.O. I the signed by Division of Vital Records, should be been after death.

I Director: After this certificate has b or Attending filled in by the To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Funeral

Director

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ms 23a or 28a-f sho must be notified at

ral", or items 2 Examiner mus

"natural"

al Hygiene.

h and Mental F

item 27 i

Physician

/Medical

Examiner

the burial-tran and

nent of Department of Important: If it any injury or o

Medical

the

traumatic event,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

State

Registrar

Medical

BRA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number RES

000

29d. Date signed (Month, Day, Year)

13

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

end manner stated.

GABLIEL

600 North Wolfe St, Baltimore, MD, 21287

January

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 - Homicide

29a. Certifier

JAN 19

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 1^D7^y 20 TO 3:00 AM LEMUEL DWIGHT RIGGLEMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CAROLINE DENTON CAROLINE NURSING HOME Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days AUGUST 23, 1937 WEST VIRGINIA 235-56-1428 Director 72 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits must be notified at Director WYE MILLS 1 Yes 2X No **MARYLAND** TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21679 28805 DOLVIN CIRCLE UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Y4954-1962 the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CATTLE HERD MANAGER other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EMMA PINGLEY ISAAC FRENCH RIGGLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 28805 DOLVIN CIRCLE, WYE MILLS, MD 21679 CAROL SUE RIGGLEMAN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o X Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY CENTREVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Name and Address of Facility LLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 8 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 ease, or complic caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Ente shock, or heart failure. List only one cause on each line. Interval Betweer immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ wer Medical Due to (or as a conseq enc) of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 Yes 2 No been signed by the atte should be detached for Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2- No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural work 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Registrar

30. Name ay

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

address of person who completed cause of death (Item 23a) (Type, Print)

20

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 2315 SALLY ANN ROWLAND 2010 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death . PININSULA 3A1136UN NICOMICO Social Security Number If Under 1 Year If Under 24 Mrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 10-23-1 M 2 F Days 230-48-1587 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No VA ACCOMACK MAPPSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 29331 MAPPSVILLE RD 23407 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Specify: BLACK 1 ☐ Yes 2 ☒ No Specify: Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC CAREGIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LORD SAMPLE MARY WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31909 <u>DAVID D. ROWLAND</u> COLUMBUS ARMOUR RD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3, 🗀 Removal from State FIRST BAPTIST CEM Donation 5 D@ther (Specify) 01-23-10 MAPPSVILLE. 21. Signature of Funeral Service 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., ACCOMAC. VA 23a fart 1. Enter the di Ns., or comolio rions in vivaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a fause on a fact line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami physician and the burial-transit The law requires that the death certificate be executed Cause (Disease of linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 BreastCA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Mnpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

BA3

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Registrar

(Check

29b. Signature

Certifying

and title of

Carroll St. Salisbury, MD. 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

100

examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

450497

Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day **GEORGE** EDWARD RICKELS 3:49 PM JANUARY Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL TOWSON BALTIMORE Social Security Numbe If Under 24 Hrs. **Funeral** 8. Date of Birth ace (State or Foreign Month, Day, Year)
JUNE 30,1966 1 ▼M 2 □ F Months Days Hours Min Country)
MARYLAND Director 43 220-90-7990 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 k√ Yes 2 □ No MD. BALTIMORE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1714 LINDEN AVE. 21217 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner 9 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: Year or Dates WHITE Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 EVENT PLANNER EVENT PLANNING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev GEORGE RICKELS **EDWARD** SR. NANCY EUGENIA KONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 LINDEN AVE., SCOTT M. WILFONG/FRIEND BALTIMORE, MD. 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1-15-2010 CHAMBERS CREMATORY RIVERDALE. 22 Name and Address of Facility CHAMBERS FUNERAL 5801 CLEVELAND A . Signature of Funeral Service Livenses HOME M00091 AVE., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ADULT RESPIRATORY DISTRESS SYNDROME Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) HUMAN IMMUNODEFICIENCY VIRUS or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year this certificate has been signed by the rail director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PANCYTOPENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ᇛ 2 No 1 🗌 Yes Other: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After the filled in by the funera 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31826 1-12-10

Registrar DHMH 17 Rev 7/2009

State

Sichard

RICHARD LINTHICUM,

31. Date filed (Month, Day, Year) **JAN 15** 2010

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M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day George Robinson Ricks January 9 2010 10:22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□ F Months Days Hours Min. 85 578-20-7412 9. 1924 Oct. Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits District of 1 X Yes 2 □ No Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1702 4th Street, NW 20001 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1942-African-If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 N Divorced 1945 American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chicago Board of Elementary/Secondary (0-12) College (1-4or 5+) Education Director of Human Relations 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Eugene Ricks Marguerite Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Hicks/Daughter 5461 Hildebrand Ct; Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 1/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville PIke; Rockville, MD 20852 ₩01463 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Cardio Respiratory Failure Due to (or as a consequence of): Multiple Myeloma Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Chronic Hypertensive Heart Disease resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performe

Physician /Medical Examiner

be executed

law requires that the death certificate

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Records,

of Vital

Division

Physician:

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show

d other than "natur

7 Is marked other traumatic event.

Health a

permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Maryland 21215-0036

altimore.

Examiner Physician/Medical ð Completed

ending physician and use as the burial-transit detached signed by t page 2 s this certificate Be Certification: To funeral (spital or Attending F lours after death. neral Director: After y filled in by the funer. After

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 1 □Yes 2 No 26. Place of Death (Check only one)

> > 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Deat!

1 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

6 Could not be

Hospital:

2 ☐ ER/Outpatient 3 🖸 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 X Natural

2 Accident

3 🗌 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D63232 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Gomez 31. Date filed (Month, Day, Year,

JAN 20 2010

15245 Shady Grove Road #130; Rockville, MD 20850

and manner stated

2. Registrar's Signature

State

within 24 hours a To the Funeral Completely filled To the Hospital

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Doris C. Rittermann 10:30 p^M January Medical 8 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Highland Howard Country Gardens Assisted Living If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 XF Days Hours 467-38-8858 82 1/2/10671927 Yrs **Director** OK Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 8802 Shining Ocean Way 21045 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 | th and Mental Hygiene. 7 is marked other than "r. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Noel B. Cummings Agnes M. Gruber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Herman P. Rittermann - Husband 8802 Shining Ocean Way Columbia, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 1-26-2010 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ e men disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Box 68760 SB IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 5 Other (specify) Day Year detached 1 ☐ Yes ∠ the 9 Unknown P.O. signed by significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performe 2 X No 1 Tyes 2 Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Tes မ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural (Month, Day, Year) injury thin 24 hours after death.

the Funeral Director; After impleted filled in by the fun Accident 5 Pending work? 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MD 2070 Ba 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2100 M 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** GNNAPOLIS rundel OE M If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth Security Numbe **Funeral** Months 1 □ M 2**XX**F Days Hours *M*T677916 MD Director 213-22-0702 Usual Residence of Decedent 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland Director Anne Arundel Shady Side MD 1 ☐ Yes 2x1x1No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20764 USA 1476 Snug Harbor Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes XX No Maryland 21215-0036 Specify: White 1 ☐ Yes 🗶 🗙 No If Yes, Give 3XXWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Pharmacy 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked viury or other traumatic eviury or other traumatic evi Elizabeth Lee Andrew Phipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shady Side, MD 20764 1416 Snug Harbor Rd. Donna Rogers Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodfield Cemetery 1/18/2010 Galesville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses 12 Ridgely Ave. Annapolis, MD 21401 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ SCASNE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to or us a consequence of ttending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death ceraficate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed death? 2 🗌 No certificate After this certifice funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar cause of death (Item 23a) (Type, Print)

Registrar's Signature

and address of person who completed

JAN 19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marilyn J. Sullivan ĬĨ,2010° 8:37 PM January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. June 17 Year 1930 Michilygan 386-30-8490 79 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Montgomery Village Maryland | Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 20886 19310 Clubhouse Road, Apt. 110 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed witt. Mental Hygiene. ∘d other than "r → the M (Specify only highest grade completed) (Give kind of work done during most of working Non-Profit life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Association 1 Meeting Planner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ဂ Lillian Connely Abraham Koven traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 i 225 High Timber Court, Gaithersburg, MD 20879 Lillian Brotons (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 14, cemetery, crematory or of Metropolitan Crematory 1 Burial 2 Cremation ö Department of Important: If any injury or once. 2010 4 Donation 5 Other (S) Alexandria, Virginia DeVol Funeral Home, 22. Name and Address of Facility ture of uneral Servi 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heartfailure. List only one cause on each line. hock Immediate Gause (Final diseas indition resulting in death) Onset and Death Chronic Obstructive Pulmonary Disease Physician/ Medical Due to (or as a consequence of): **Examiner** Non Small Cell Lung Cancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 g Unknown signed by the a Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an s certificate has the director, page 2 s performe death? 1 Yes 2 No Yes 2 X No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Tes 2 XNo မြ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After years. (Month, Day, Year) 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No M Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title of certifier

TAWAD

31. Date filed (Month, Day, Year)

JAwad Arshad, M.D.,

JAN 15 2010

ARSHAI)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9901 Medical Center Drive, Rockville, MD 20850

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00067762

29d. Date signed (Month, Day, Year)

JANUARY 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Salvatore Paul Suffanti January 14, 2010 9:33 aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) July 25, 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Months Hours 109-24-5104 79 193d **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Silver Spring Montgomery 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20902 USA 4011 Ingersol Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. 1948-70 White Completed 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communication Specialist Federal Government and Mental Hygie is marked other Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked or ည Rose Poeta Joseph Philip Suffanti injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Mark J. Suffanti/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4200 Tulare Drive, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1.
Department of Important: If it any injury or o once. Jan. 15 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licenses 2Francisdoss of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiomy o and disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, reading to in finediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (ur as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No requires that the death Year Month 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Records, Kirdnew 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 Yes 2 No Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Hospital 2 No မ 1 🗌 Yes 1 V Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? 1 \(\text{Yes} \quad 2 \(\text{No} \) Natural 5 Pending injury Division 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) Jan. 14, 2010

State Registrar

10+1

(41)

0933

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atul Rohatgi, MD

10061302

8600 Old Georgetown Road, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Seay 4enth 736 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** 4c. If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Min (Month, Day, 08/12) 226-98-8357 45 Months Hours Director Washington, DC Usual Residence of Decedent fshov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral 28195 Bishops Court 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give þ Maryland 21215-0036 1 Tes 2 No Specify. white Specify. "natural", 3 - Widowed 4 - Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Millard C. Seay Margaret Lightner . Page 1 and 2 should ment of Health and M tant; If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28195 Bishops Court, Salisbury, MD 21801 Jennifer Seay/spouse Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tment of Important; If i any injury or o 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 1/18/10 Salisbury, MD permit. 21. Signature of Funeral Service Li 2 Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd. Salisbury, 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the b IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ jo in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No the Unknown detached P.0. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 \square Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? certificate 1 Yes 2 No of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🗹 Natural (Month, Day, Year) 5 Pending Division Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Check oni Certifying se Practioner: To the best of my knowledge, Jeeth benum d at the time, date and plane, and due to the nause(s) and manner as stated 29b. Signatu 2 tle of certif 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Rd. SALISBURY, MD

who completed cause of death (Item 23a) (Type, Print

32 Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 January 16 8:14 A M Raymond Lee Spence 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1**X** M 2□ F 152-30-9505 69 5-6-1940 MD Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Wicomico MD Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 U.S.A. 711 Meadowwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Somerset Co. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Spence Hattie Dashiell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra White/Daughter 711 Meadowwood Dr, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place)
Macedonia Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2010 Westover, MD Park 22. Name and Address of Facility 17 W. Isabella St. 21. Signature of Europa Funeral Home Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fedure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Come (Final disease or condition resulting in death) ENTENTIL ALZHEIMERS Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Department of Health a Important: If item 27 is any Injury or other tra

Physician

Examiner

Funeral

Director

show

28a-f

23a or

items

9

"natural",

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

Pages 1 and 2 should

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

with the Maryland

death v

Maryland 21215-0036

Baltimore,

/Medical

Examine ed by the attending physician and detached for use as the burial-tran Physician/Medical as Completed by has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be P Certification:

State Registrar

Medical

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahesha Thimmarayappa, MD 614 Eastern Shore Dr., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

JAN 20 2010



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:56 P M 2010 18. JAN GERALDINE STANGE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL LINTHICUM TATE HOUSE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 💢 F Yrs. 1928 WASH. D.C. 81 **Director** 577-38-1173 Usual Residence of Decedent 10d. Inside City Limits illed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exertiner must be notified at 1 ∑Yes 2 □ No Director PRINCE GEORGES HYATTSVILLE MD. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 20784 6929 EMERSON ST. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ð 3 ☐ Widowed 4 X Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) NURSING PRACTICAL NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be MONTGOMERY MARY **BERNARD** S. SPALDING မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 4305 KENNY ST., BELTSVILLE, MD. 20705 Department of Health Important: If item 27 any injury or other tr PATRICIA JENNINGS/DAUGHTER Baltimore. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVET CEMETERY 1-22-2010 WASHINGTON, D.C. 21. Signature of Funeral Service Licenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A Chambersa 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 -M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC PANCREATIC CARCINOMA 8 MONTHS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of) Examine be executed burial-transi and Due to (or as a consequence of) attending physician Physician/Medical the 98 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🎛 No 5 Other (specify) P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown BULLOUS PEMPHIGOID page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATHEROSCLEROTIC HEART DISEASE autopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be HOSPICE HOUSE Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the Pwithin 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37934 JAN. 19, 2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar STEPHANIE TRIFOGLIO,

JAN 20

31. Date filed (Month, Day,

, M.D.
3 Registrar's Signature

DHMH 17 Rev 1/2001

7500 GREENWAY CENTER DR., SUITE 430, GREENBELT,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF. G901, 3/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 13^{Day} Physician/ Abdus Samad Month Syed Mohammad М 2010 2205 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 / 1 / 1 9 3 4 Days Hours Min 1 X M 2 🗆 Director 214-51-5135 76 Bangladesh Usual Residence of Decedent Show or 28a-f shov be notified at 10a State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Md. Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23a or the Medical Examiner must be Funeral 20906 U.S.A. 13123 Foxhall Dr. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No 1 ☐ Yes 2 X No Specify. Specify: asian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene.
ant. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Bangladesh Airforce Bangladesh Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abdur Raheem Sabor Nessa 19a, Informant's Name/Relationship (Type, Print)
Fazilatun Nissa Samad
Syed Farooq/ son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13123 Foxhall Dr. Silver Spring, Md. 20906 Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 1/15/2010 Adelphi, Md. 4 Donation 5 Other (Specify) George Washington! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary Narten orely Kennedy St., NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Brain noxic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner elar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last ongesti Due to (or as a consequence of): iabetto Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the a should be detached f 1 ∐ Yes 2 L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sign ature and title of certifier 3 1/14/2010 MD 00068026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Padmaia Bandi Olney. Md мD 18101 Prince Philip Dr. 20832 Registrar's Signature 2 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MARYLAND BATIMORE NEDICAL CONTO Date of Birth (Month, Day, 3 - 28 Birthplace (State or Foreign Country) if Under 1 Year I If Under : **Funeral** Year Months 1 ☐ M 2 🔼 F DELAWARE 222-56-0112 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinating the rottilled at 1 ZYes 2 □ No HARRINGTON Director KENT DE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 and 2 should be filed within 72 hours after death with 19952 GRANT STREET /// USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DRIVER SCHOOL SYSTEM 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARLENE L. LORETTE ABEL FRANKLIN ٤. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau FIRE TOWER / HUSBAND ROAD FELTON STEPHEN SHAPPEE 3983 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State GREENWOOD. 1-23-10 4 ☐ Donation 5 ☐ Other (Specify) JOHNSTOWN CEMETERY 21. Signature of Funeral Service Lige 22. Name and Address of Facility POB Steam Hone GRE

23a. Part 1. Emir the ise so, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 19950 GREENWOOD Approximate Interval Between Opset and Death POST-FNEUMONECT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🔊 No Day Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by CARCINOMA 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SONTH BREENEST BAUTMORE, MD 21201

To the I

29c. License number

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0001 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JoAnn R. Smith January 7, 2010 ear 11:10 p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley Nursing Home Walkersville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Maryland 214-28-0569 78 Director Usual Residence of Decedent of Health and Mental Hygiene. Item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Yes 2 No Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21769 108 Prospect Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 **X X** Vo filed within 72 hours after Completed by Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (C-12) College (1-4 or 5+) Newspaper Librarian Media Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leila M. Smith Albert A. Remsburg . Page 1 and 2 should ment of Health and M tant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15805 Norman Drive, Gaithersburg, Maryland 20878 JoEllen Hansroth - daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Boonsboro Cemetery 1-13-2010 Boonsboro, Maryland 21. Signature of Funeral Service ticensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Letastatic Boain Cancer: MC h Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dua to (or as a consequence or) CO PO and burial-tran Due to (or as a consequence of) ũ resulting in death) Last attending physician Physician/Medical certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ho

9 Unknown or Attending Physician: The law requires that the death for Month Vear 5 Other (specify) Pregnant at time of death Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ erosis with Valve replaced 1 Yes 2 No 3 Probably 4 Junknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) ne Hospital or Attending Pt n 24 hours after death. The Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Afi completed filled in by the ful 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 1) 11 10

DHMH 17 Rev 7/2009

State

Registrar

maatinklesse

31. Date filed (Month, Day, Year)

Jarka

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Machine Rece 300 w. 9 h > tweet Torolombo Mo

32. Registrar's Signature

0

			1- State of Maryland / Dep Perfy FCHD KS 1/19	artment of Health and I Prificate of Death	Mental Hygie Reg	ene . No. 2 A I A	0291
	Physici		Decedent's Name (First, Middle, Last) Mae Anna Schone		2. Date of Death Month	Day 14 2010	3. Time of Death 1:30 P M
-	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
11			Citizens Nursing Home	Frederick If Under 1 Year If Under 24 Hrs.	100000000000000000000000000000000000000	Freder	
ı	Funeral Director	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 S F 75 Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, Y	1934 M	place <i>(Sta</i> te o <i>r Foreign</i> ntry) D
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e Mar 8a-f sh	ector		idd1etown			1 ∐ Yes 2 🙀 No
	h with th	al Dir	3297 North Hill Ct.	10f. Zip Code 21769	10g	. Citizen of What Cou US.	•
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Experiment rust be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 No Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 3 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
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Maryland	uld be file Mental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last) Morice O. Ditto		ne (First, Middle, Mai Schweitz	,	
	and 2 sho salth and I 27 Is ma er trauma	ľ	19a. Informant's Name/Relationship (Type. Print) Lisa Kirkendall (Daughter) 329	ng Address <i>(Str</i> eet and Number or Ru 7 North Hill Ct	ral Route Number, C	lity or Town, State, Zi, $1 {\sf etown}$,	MD 21769
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Ma. Once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Spegify)	urg Crematory17	Date 200 19/2009 9/2010	c. Location - City or To Smithsbu	rg, MD
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	Physician		23a Part 1. Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac		,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
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68760,	ficate be executed physician and s the burial-transit	edical Exa	resulting in death) Last C. Due to (or as a consequence of):				
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/ita	siclan; The certificate h rector, page	Be C	25. Was case referred to medical examiner?	26. Place of Dea	1 ∐ Yes 2 th (Check only one)	DNO TOTES	2 LINO
of\	Physi this c	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	72		e 6 □Other (Speci	fy)
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Division	al or Attend after death Director: , Director: do in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical C	29a. Certifier (Check only one) **Check only one Check on	exestigation in my oninion, death occur	rred at the time date	and place, and due t	o the cause(s)
	To ti withi To ti	Ĭ	29b. Signature at title of certifier	29c. License number	29d	Date signed (Month,	Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number DOOS 2223 Print) DUVE FLED		7 (1/10	6.7
	Sta	to	12 AYE EN SOLMUM, M 196 31. Date filed (Month, Day, Year) 32. Registrar's Signature	IS DLIVE FRED	EHCK, -	11-211	02
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ROSLYN ELIZABETH STOKES 4:05 P M JANUARY 14, 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BEL AIR HARFORD UPPER CHESAPEAKE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
APRIL 18,1957 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 52 169-48-1332 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f sho event, the Medical Evandour must be notified at Y Yes 2 □ No Director **EDGEWOOD** MARYLAND HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1941 EDGEWATER DRIVE, APT D 21040 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT NURSING HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Pages 1 and 2 should be f nent of Health and Mental GRADY MALONE GENEVIEVE STOKES ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) (O) ROCHELLE STOKES / DAUGHTER 1622 SWALLOW CREST DRIVE, APT F, EDGEWOOD, MD 21040 27 other permit. Pages 1 and Department of Healt Important: If item 2: any injury or other: timdre, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State R A FERRIS & CO. INC: 01/22/10 4 □ Donation 5 □ Other (Specify) WEST CHESTER, PA 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee Coleman 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Seizure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2: autopsy 25. Was case referred to medical examiner? performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ပို Division of Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/200

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** 3:50p M 2010 Josephine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Catonsville Baltimore Charlestown Care Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month. Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🛛 F 82 216-20-3144 July 11,1927 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Department of Health and Mental Hygiers. In the state of 1 ☐ Yes 2 X No Catonsville Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 717 Maiden Choice Lane, Apt. 504 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 □Yes 2 🛚 No Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Principal 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Serio Rose Tamburo ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 866 Shore Acres Road Arnold, MD 21012 Neal V. Fertitta / Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 23 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Baltimore, MD New Cathedral Cemetery 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 3 Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of)! Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if only lead to limit a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) s been signed by the s 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 □Yes 2 ☑ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

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State Registrar 29b. Signature and title of certifier

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31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

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32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

hoice Lane, Catonerille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12°, **Physician** 2010 Sellner January 9:50 Рм В. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (S (Month, Day, Year) 12,1918 Mary Land 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 91 578-12-6137 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, he Medical Examiner must be recitified at 1 ☐ Yes 2 No Director Maryland Prince George's Camp Springs 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with USA 20748 6909 Mackson Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2 No Specify Specify: White þ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington, D.C. 1 and 2 should be filed within Health and Mental Hygiene. em 27 ls marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Bernice Pyles Affron William Ariste ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is-any injury or other traus 9615 Pierrpont St., Burke, VA 22015 Charlene Y. Sellner -Daughter 20b. Place of Disposition (Name of Be 115 "M" Ruff Ch Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 1/23/2010 Camp Springs, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signat of Funeral Service Licensee 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-t Box 68760, physician Physician/Medical the as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month Year Dav in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 perform 1 ☐ Yes 2 ☐ No 2 **X**No 1 ☐ Yes Division of Vital Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINE CENTER WALDERF, Md. ZOLO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

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32. Registrar's Signature

Physician. Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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12 years 17. Father is Name (First, Middle, Last) 18. Mother's Name (First, Middle, Markden, Suramen) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18. Informatis Name/Relationship (Type, Print) 190. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Oakwood Circle Dickson, Tennessee 37055 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Oakwood Circle Dickson, Tennessee 37055 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18. Mother's Order (Specify) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street And Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street And Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street And Number or Rural Route Number, City or Town, State, Zip Code) 19. Mailing Address (Street And Number or Rural Route Num				I 16a	(Give k	ind of work done d		ing	16b.	Kind of Business	Industry
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19b. Informant's Name/Relationship (Type, Print) Annette Groen / Niece 19b. Mailing Address (Street and Number or Furnil Houte Number, City or Town, State, Zip Code) 116 Oakwood Circle Dickson, Tennessee 37055 20a. Method of Disposition 11 Si Bural 2 circemation 3 Removal from State 4 Donation 5 Other (Specify) 4 Donation 5 Other (Specify) 21. Signature Funcial Reprise Licensee 22. Signature Funcial Reprise Licensee 23. Signature Funcial Reprise Licensee 24. Signature Funcial Reprise Licensee 25. Was a decedent pregnant in the past 12 months? 1 Pregnant at time of death 25. Was decedent pregnant in the past 12 months? 1 Pregnant at time of death 25. Was decedent pregnant in the past 12 months? 1 Pregnant at time of death 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to resulting in the underlying cause given in Part I. 25. Was case referred to medical productions contributing to death four to result in the part of the part of part of the part of the part	17. Father's Name (First, Mic						18. Mother's Nam				
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21. Signature in Funcy Ferrigo Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A.	1 🛛 Burial 2 ☐ Crem		lemoval from State	cemete	ery, crem	atory or other place	e) :				
23a. Plan't. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Consett and Death Consett and De			•	Wasii, I	22.	Name and Addres	s of Facility G	eorge P.	Kala	s Fimeral	Home P.A.
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Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause Disease or liniply, that inhibited events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ves 2 No 3 Probably 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ves 2 No 3 Probably 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 Unknown 9 Unkn	Immediate Cause (Final disease or condition	List only one	Cause on each line.	LONA	RY	ARTE	RY DI	SEAS	E	1	
Due to (or as a consequence of): Cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last			Due to (or as a c					-			
that initiated events resulting in death) Last Columb	if any, leading to immediate cause. Enter Underlying		Due to (or as a c	onsequence	of):		-				
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23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death 3 Ectopic pregnancy		d									
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APOCMINAL ARRIL ANE YRYSM 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 5 Pending Investigation Sucicide Accident Sucicide Accident Sucicide Sucicide Accident Sucicide Accident Sucicide Suci					in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
25. Was case referred to medical examiner? 1	1							1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
25. Was case referred to medical examiner? 1						KYSM		autor perfo	rmed?	prior to death?	completion of cause of
1	25. Was case referred to me		10 1111	CIVE		26. Pla	ce of Death (Check		2 🔼	lo 1 ∐ Yes	2 No
1 Natural 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined Set. (Specify) 29a. Certifier 1 Set. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.		Ho	ospital: 1	2 🗆 ER/O	utpatient	3 DOA Othe	r: 4 XNursing Ho	me 5 🗆 Resid	dence	6 ☐ Other (Speci	ify)
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.	1 Natural 5 🗆 F					work's)	28d. Describe h	ow inju	ry occurred	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.	3 Suicide 6 0	ould not be			arm, stre						al Route Number,
(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sta	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.										
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	only one) 3 Cert	ifying Nurse	Practioner: To the be	st of my know	vledge, de	eath occurred at the	time, date and plac	e, and due to the	e cause	(s) and manner as	stated.
D45217 1/13/2010	•	as	my.			1245	5217			1/13/.	2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adebowale Ajeji 6201 Greenberg Berryn Hts MA 20740	30. Name and address of pe	rson who con	npleted cause of dear				eit #Mis	Beru	17N	HFS MD	20740
31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 19 2010 Leves B. Land			32. Registrar's	Signature 8.	do	arks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 **Physician** 5:30 A M January 14, Shipe Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol1 Westminster Carroll County General Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min. 1 □ M 2 🔯 Months December 6, 1925 Director 208-18-6477 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Svkesville Carrol1 Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 23a 1325 Buckhorn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 TNo Specify: 2 Specify: 3 ☑ Widowed 4 ☐ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Italia. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Malinowski Tewis Wisniewski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12608 Marleigh Drive, Bowie, MD 20720 Roberta James-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland Jan. 16, 2010 Atlantic Crematory 22. Name and Address of Facility 21. Signature of Fupera Service Licensee Fleck Funeral Home, INC.
7601 Sandy Spring Road, Laurel, Maryland 20707
Sandy Spring Road, Laurel, Maryland 20707
Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin burial-transi Due to (or as a consequence of): Box 68760, been signed by the attending physician should be detached for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.O. □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>S</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 ₽No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊡*No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital ewithin 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Opting basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month)

Elderslup

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

)Ulte

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Ε. Taylor Sr. 1^{Day}, 2010^{ear} 5:33 January AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year 21 St 22 . Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. **Director** 213-58-5309 54 Maryland 195 Usual Residence of Decedent show 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. ant: If ifew 27 is marked outher than "natural", or items 23a or 28a-f sho ant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Montgomery Gaithersburg 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 101 Odenhal Ave. #1015 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 💢 No Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Box Corrugation Warehouse Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Glenn Taylor Mildred Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $11857\ Skylark\ Road\ Clarksburg,\ MD\ 20871$ Pamela M. Taylor (Daughter) Department of Health Important; If item 27 any injury or other th Date 16, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rockville, MD 2010 4 Donation 5 Other (Specify) Parklawn Mem. Pk. permit. F 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Minutes Ph_sician/ Gastrointestinal Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed?
Yes 2 X No filled in by the funeral director, page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 X Yes 2 🗌 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 🕅 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one)

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year)

JAN 15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registra

29c. License numbe

56

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Carroll Thompson James January 2010 2:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min OCt. 21, 1922 1**X** M 2 □ F Maryland Director 216-18-1161 87 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎦 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4604 Harlan Street 20853 USA ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
If Yes, Give 1943-11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 XNo Specify: Year or Dates. 1943-52 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cryptologist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jerome Thompson Nellie Johns 19a. Informant's Name/Relationship (Type, Print) -Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Lourdine Thompson 4604 Harlan Street, Rockville, MD 20853 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Jan. permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Gate of Heaven Cemetery 1 M Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090 21. Signature of Funeral Service Licensee 23a. Part 1. Dater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): complicate the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Certificate: To Be Completed by Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Yea 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lymmonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6099 MI) 13 10 10 huna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18404 Oxfordshire Terrace, Olney, MD 20832 Aruna K. Paspula, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 18/2010 MELVERENE EDNA THIEL 9:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 10/16/192 Yrs Director 243-28-8016 88 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a, State Director 1 X Yes 2 □ No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4308 Glenrose Street 20895 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give ģ 1 Never Married 2 Married 1 Yes 2 No Specify. White Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Public Speaker Textile Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Lonnie Boger Jennie Mae Collette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4308 Glenrose Street, Kensington, MD 20895 Greg Thiel - son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State tery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) toh's Church Cem. 01/22/10 22. Name and Address of Facility Snowden Funeral Home Signa of Funeral Service Lic 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician/ Medical Due to (or as a consequence of): Examiner Alzheimers disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Dementia Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 X No 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice

death certificate be executed sician a Box 68760 phys. attending p for use as t been signed by the should be detached P.O. Records, page Hospital or Attending Physician: The certificate of Vital Division he Funeral Director: / within 24 hours a

23a or 28a-f show

the Medical Examiner must be notified at

"natural", or items

filed within 72 ltal Hygiene.

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i

Baltimore, Maryland 21215-0036

Certificate: Medical

27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending X Natural 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

only one) 29b. Signature and title of certifier

(Check

31. Date filed (Month, Day, Year

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

29c. License number 01/18/2010 D60634

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph 1160 Varnum Street, NE, Washington, DC 20017

Registrar

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 01712/2018 1701 JESSE J. TURNER 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, 1**∑** M 2□ F 01/23/1942 579-54-4798 67 VA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1316 Fenwick Lane, 20910 #808 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 196
If Yes, Give
Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1963-1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced 1969 Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metro Transit Elementary/Secondary (0-12) College (1-4or 5+) Trackman Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Bernice Branch Harold Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie N. Turner - wife 1316 Fenwick Lane, #808, Silver Spring, MD 20910 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 1/15/10 Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service Lit ensee 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Fin disease or condition Acute myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiac arrest leading to anoxic encephalopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 1 X Natural
2 ☐ Accident 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

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Funeral

Director

item 271s marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

death

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than

Department of Health ar Important: If item 27 is any injury or other trau

altimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

After t

al or Attending P s after death. Il Director: After t ed in by the funera

To the Hospital within 24 hours a To the Funeral L Hospital

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certificate be

and burial-trar attending physician the as ISe or signed by the a page 2 s has certificate this

Examine Physician/Medical þ Completed Be Certification: To

3 Suicide

29a, Certifier

4 Homicide

1 ☐ Yes 2 🗆 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/13/10

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

investigation

determined

6 ☐ Could not be

29c. License number

H64588

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 20 2010

Ashisha Tolia



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health State of Maryland / Department of Health Certificate of Deat			2010	02929			
	Dhusisi		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death			
2	Physicia /Medic		Donald Gates Joseph Patrick Thompson	J	anuary	17, 2010	7:44 A M			
and and	Funeral Director	er	579-44-8703 1XD M 2□ F 74 Yrs. Months Days Hours Usual Residence of Decedent	der 24 Hrs. 8. rs Min.	Date of Birth (Month, Day, Yuly 3,	1935 Wash	mery lace (State or Foreign try) ington, D.C Od. Inside City Limits			
	/aryla f shov	ō				["	1 ☐ Yes 2 ☑ No			
	r 28a-	Director	Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code		10g	, Citizen of What Coun	try?			
	23a o		24601 Tandem Drive 20872			U.S.A.				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, it is hearlest hard and injury or other traumatic event, it is hearlest hard hard and once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		y Yes or No- an, etc.)	14. Race - Americ Black, White, e	etc.			
2-0	72 ho 'natur	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	nost of working	16	b. Kind of Business/Ind	dustry			
121	within iene. • than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 Firefighter			District (Columbia	of			
nd	e filed al Hyg rother vent,	BeC		other's Name (Fi	irst, Middle, Ma					
З́а	ould by Ment arked natice	ျှ		ry Laura	_					
<u>B</u>	nd 2 sh ulth and 27 is n r traun		19a. Informant's Name/Relationship (Type. Print) Theresa L. Thompson - Wife 24601 Tandem Driv				,			
Baitimore, Maryland 21215-0036	es 1 ar of Hea litem		20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date		Maryland c. Location - City or To				
<u>E</u>	t. Page tment tant: It jury o		4 Donation 5 Other (Specify) Metropolitan Cremator		22/20	lexandria,	Virginia			
Bai	permit Depar Impor any In		21. Signature of Fund al Service Up nsee Villaurs 22. Name and Address of Fam Molesworth—Williams 26401 Ridge I	illiams Road. I)amascu	s. Maryland	20872			
2 1	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	n as cardiac or re	espiratory arres	t,	Approximate Interval Between Onset and Death			
	g physician and street transit the burial-transit t	ledical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	Di'sc	18e					
P.O. BOX hat the death cert	death cert e attendin d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of delive	ery Day Year			
	w requires that the of been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	23e. Did toba	id tobacco use contribute to the cause of death? ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown					
Ï	Ine lar ate has bage 2	Completed			24a. Was an autopsy performe 1 □ Yes 2	prior to condend?	psy findings available impletion of cause of			
3 3	s certif	o Be	examiner?	lace of Death (C						
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific.	fer this	n: T	1 Yes 2X No							
	or Attendig after death. Director: A	Certification; To	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)							
Hospital 24 hours a Funeral L		ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, on and manner stated.							
:	vithin To the compl	Me	29b. Signature and title of certifier 29c. License number	I. Date signed (Month,	Day, Year)					
			> 37 /W Dec6	2435		1/18/2	0/0			
1	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			D1 .77	20850			
	Sta Registra		Sayed Elsayyad, M.D. 10110 Molecular Drive 31. Date filed (Month, Day, Year) 12. Registrar's Signature 12. Jan 19 2010	e - Suit	e 206,	<u>Rockville</u>	, Md.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jan 2010 Julia Ann Trice 3:43a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil E1 kton Union Hospital Birthplace (State or Foreign Country)
 DE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** June 12 1 🗆 M 2 🔯 F DE 79 Director 222-16-6447 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No MD Cecil E1kton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21921 118 Elkmore Rd. should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No 21215-0036 1 Yes 2 XNo White Specify: "natural" 3

Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ Emily Hill Daniel Reardon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Crocus Ct. Conowingo, MD 21918 Joan C. Carr/ daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State /26/2010 1 X Burial 2 Cremation 3 Removal from State Cemetery Delaware Vet. Memorial Bear, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility
R.T. Foard & Gee Funeral Home Signature of Suneral Solvice Licensee any E Main St. Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ₪ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: ER/Outpatient 3 DOA ည 1 X Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural 1 Yes 2 No 2 Accident Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) loria MI monson

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		1	Please Type or Print in Black In State of Maryland / Dep 1 - State Registrar 1. Decedent's Name (First, Middle, Last)			93 Death				
e.	Physici /Medio Examin	al	Robert Elwood Wimbrow, Jr. 4a. Facility Name (If not institution, give street and number) 116 C Fox Circle	4b. City, Town, or Location of Death	Jan. 18, 2010 Year 2:45					
	Funeral Director		5. Social Security Number 220 – 90 – 7635 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthda) 7 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State of June 20. 1971 MD	or Foreign				
4+ 04+ 04- 04- 04- 04- 04- 04- 04- 04- 04- 04-	Hygiene. Hygiene. than "natural", or items 23a or 28a-f show ent, the Medical Eveniner in ust be notified at	rector	10a. State 10b. County 10c. City, Town or to MD Wicomico Salisbury 10c. Street and Number		10d. Inside Cit 1 □Yes					
4	ns 23a or	Funeral Director	116 C Fox Circle 11. Marital Status 12. Was Decedent Ever in U.S. 13	21801 Was Decedent of Hispanic Origin? (Si	USA pecify Yes or No- 14. Race - American Indian,					
OCOO	ural", or item	þ	11 Never Married 2 Married 1 Yes 21 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	. Was Decedent of HispanIc Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒No Specify:	_{Specify:} white					
Z 1 Z 1 3-00 30	tal Hygiene. d other than "nattevent, the World"	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 15. Decedent's Education (Giv. 16a. Dec. (Giv. 16b.) College (1-4or 5+) Disal	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) DIEd	king N/A	16b. Kind of Business/Industry				
		To Be (17. Father's Name (First, Middle, Last) Robert Elwood Wimbrow Sr.	ne (First, Middle, Maiden Surname) Garrison						
iore, ma	permitter ages in the annual conductor of permitter if them 27 is marked any injury or other traumatic events.		Robert E. Wimbrow, Sr./father Rt 20a. Method of Disposition 1 Burial 2 DXCremation 3 Removal from State Cemetery, or Canal Removal from State	12, 1544 Stockton, position (Name of ematory or other place)	Date 20c. Location - City or Town, State					
baltimor	Departmer Important any injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bu 08 William Street	rbagen Fungral 8Home	_				
be executed	hysician and ke priid-transit	cal Examiner	23a. Part / Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ATAXIA	c or respiratory arrest, Approximate Interval Better Onset and D	ween				
the death certificate	y the attending phiched for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day	Year				
law recliires that	en signed b	ρλ	Part in Other Significant conditions contributing to death out not resulting in the underlying cause given in Part i.							
מו שפו יות דים דים שפו היום יות	ficate has be	Completed			24a. Was an autopsy autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No					
UIVISION OF VITAL RECORDS, P.O. BOX 68/ To the Hospital or Attending Physician: The law requires that the death certificate	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 20 No							
L Hosnital	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Chack only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Jo _T	To t	M	29b. Signature and utle of certifier	29c. License number R08453	29d. Date signed (Month, Day, Year) 1/19/20/0 Calishury MD =1804					
B	A 5	te	30. Name and oddress of person who completed cause of death (Item 23a) (Type 12b Milfaro 31. Date filed (Month, Sey, Year) 32. Registrar's Signature	29. License number RO8953 P. Print) St. Ste. 504B,	Salisbury MD 21804	P				
DHWI.	Registr		JAN 2 0 2010 Janua S.	Garke .						

DHMH 17 Rev 1/2001

10-00425 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brian Lee Wagner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0930 hrs Brian Wagner **Medical Examiner** Lee January 15, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Deal Island Somerset Wenona Harbor 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours Months 269-70-1554 Director Country) Ohio 37 12/16/1972 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 1 Yes 2 No Maryland Wicomico Salisbury 28a-f show , or items 23a or 28a-f shore, must be notified at once. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27530 Trotters Run 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No 1 Yes permit. Pages I and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Inferent: If item 27 is marked other than "natural", or injury or other traumatic event, the Madical. 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: white ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 owner/operator golf/fishing 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Leroy Wagner Joella Mae Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nicole Wagner/spouse 27530 Trotters Run, Salisbury, MD 21801 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory Salisbury, MD 1/18/10 Donation 5 Other Specify 21 Sandure of Funeral Service Lice 22 Horld Ways Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 hat sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complicational Physician failure. List only one cause on each ne Between Onset and (Medical Death a prowning complicated by hypothermia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last is been signed by the attending physician and should be detached for use as the burial - transit The law requires that the death certificate be executed sician/Medical AMENDED UNPENDED Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: director, 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 🗸 Yes After t 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject fell off a boat FOUND Natural 1 Yes 2 ✔ No Pendina within 24 hours after death. To the Funeral Director: the Jan 15, 2010 0930 hrs 2 🗸 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State)
Tangier Sound, Deal Island, MD determined (Specify) Bay Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 16, 2010 rull met

Ser

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Margarita Korell MD

31. Date filed (Month) (AP)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Norman Wexler 6:00 a January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3330 N. Leisure World Blvd., Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 6, 1933 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 □ F Months Days Hours New York Yrs Director 089-30-1767 76 Nov. Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director s 23a or 28a-f shust be notified a 1 Yes 2 1 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral and Mental Hygiene. 'Is marked other than "natural", or items 23e raumatic event, the Medical Examiner must ! 3330 N. Leisure World Blvd., 20906 #524 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces? 1 Yes 2 □ No Black, White, etc. ò 1 X Never Married 2 Married within 72 hours after 1 Yes 2 K No Specify: White If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates. 1956-58 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 Self-Employed Investments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert Wexler Pauline Bragg Page 1 and 2 should ment of Health and Mr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Syed/Cousin 10216 Windsor View Drive, Potomac, MD 20854 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Jan. 2010 Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 years Immediate Cause (Final Physician/ Parkinson's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Dementia 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery þ in the past 12 months? Month Day 1 Yes 2 No cate has been signed by the page 2 should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a Was an autopsy performed? Yes 2 N certificate ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 2 🎦 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural work? 1 Yes 2 No 5 Pendina ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760 P.O. Records, or Attending Physician: The of Vital Division s after death To the Hospital or within 24 hours a To the Funeral D

Maryland 21215-0036

Baltimore,

completed 8+

> State Registrar

Medical

29a. Certifier

29b. Signature and title of cer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Teffrev P. Indrisano, MD 6410 Rockledge Drive, Bethesda, MD 20817 31. Date filed (Month, Day, Year) 2. Registrar's Sign sture 0

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D37975

29d. Date signed (Month, Day, Year)

January 19, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:09P M 14/ 2010 EMERSON RUDOLPH WILLIAMS, SR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cherry Lane Nursing Center
5. Social Security Number
6. Sex
7. Age (In yrs. last birthday)
Yrs. Prince Georges
9. Birthplace (State or Foreign Taure L If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/11/30 **Funeral** Days Country) Min MD 218-28-3825 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at 1XYes 2 No Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21046 U.S Funeral 7089 Old Columbia Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 Specify: Black 1∐Yes 2⊠No ₽ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Trucking 10 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finand Mental F John Perkins Williams Fannie Lee Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State Zip Code) f Health tem 27 i Betty Williams / Wife 7089 Old Columbia Rd, Columbia, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 20a. Method of Disposition Pages 1 Department of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Locust UMC Cemetery 1/19/2010 Highland, MD-4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signat p of Funeral Service 246 N. Washington St., Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final RDIOMYOPATHY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed burial-transi Due to (or as a consequence of): attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f □Yes 2 □ No o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy The performed 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (

Registrar
DHMH 17 Rev 1/2001

State

ADEBOWA

31. Date filed (Month, Day, Year)

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JAN 20

6201 Greenbert rd

20740

Berwyn His MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

TAMI

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Roland 0. Woodring 2010 7:11 PМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Seabrook 9407 Jones Place . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months 1 XM 2 F Hours (Month, Day, Year) 01/04/1929 Director 81 190-20-0974 Pennsvlvania Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Prince George's Seabrook 1 Yes 2 X No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9407 Jones Place 20706 USA or items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces'
1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes Give "natural", Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 1947-52 event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Field Engineer Bendix Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be Health and Menta Otto Richard Woodring Trene Gerard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac Ardelle M. Woodring/Spouse 9407 Jones Place, Seabrook, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/25/2010 Baltimore, Maryland Crematory un al Service Licen 22. Name and Address of Facility Signature of Beall Funeral Home 6512 NW Crain Hwv., Bowie, MD 20715 Approximate 23a. Part 1. Enter the disease, or comshock, or heart failure. List only of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner sea Il Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to for as a consequence of -transit rei To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknow s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify 27. Manner of Deal 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After (Month, Day, Year) 1-Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

NH 10 YIUA State

Registrar

Medical

29a. Certifier

only one) 29b. Signe

31. Date filed (Month

Dr. Delbert Morales

19

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

115 Center Way, Greenbelt, Maryland 20770

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ m Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 6/17/1921 1 **X** M 2 □ F Months Days Hours 88 Yrs Pennsylvania Director 060-12-0755 Usual Residence of Decedent 28a-f shov at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified. 1 🗆 Yes 2 🔀 No Anne Arundel Maryland | E<u>dgewater</u> 10f. Zip Code 10g. Citizen of What Country? Funeral 3711 5th Avenue 21037 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Drafting Draftsman 12+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Steve Woytovich Anna Lengyel 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy L. Morgan/ Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 863 Holly Avenue, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1/18/10 Edgewater, MD 21. Signa and of all Service licenses 22. Name and Address of Facility George P. Kalas Funeral Home Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cele Scal 9 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, he ding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last bunat attending physician for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s performed 2 X N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 **X** No ည 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month Day, Gar) 2010

in

who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

ierna

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ John Henry Alston, Sr. P^{M} 28 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) Sept. 22 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Hours 1 M 2 F Days Months MD Country) **Director** 218-46-2624 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified a MD n/a X☐ Yes 2☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5801 Waycross Rd. 21206 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2X Married 1. Yes 2 No
If Yes, Give 2 1 No
Year or Dates. 2/1965 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 7 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembler General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ew ပ Paul Alston, Sr. Emma Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Chavis-Alston (wife) 5801 Waycross Rd. Balto, Md. 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cemetery, crematory or other place)
Garrison Forest N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/9/10 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) onature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Preston St. Balto, Md. 21213 Approximate Interval Between Immediate Cause (Final Ph_sician/ Jancocatio month disease or condition Medical resulting in death) lie to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ner Due to for as a consuluence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: in hospice မှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventioning in a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur Atitle of certifier 29c. License number 7010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

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Charles

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MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 State of Maryland / Department of Health and Mental Hygiene certain Certificate of Death Reg. No. 2 02938 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Danuta T. Araminowicz 8-30AM Lining 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 16 S. Patterson Park Avenue Baltimore City Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1/1/30 Year) 250-73-1721 1 □ M 2 🔀 F Months Days Hours Min. 80 Russia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical France. 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD 1√Yes 2 No Baltimore ND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 S. Patterson Park Ave. Funeral 21231 Poland 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 27 No Specify. \$ 3 ₩ Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Pharmaceutiseutical 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ unk Jadwiga Plage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wicz 306 E. Highfield Road Baltimore, 21218 daughter / Dr. Dorota Aramin^O 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/15/10 Glen Burnie, MD 21061 21. Signature of Funeral Service License 22. Name and Address of Facility homas Skarda Fubneral Home 2829 Hudson St. Ralto. MD 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 21224 Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical thet requires that the death certificate attending pi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day ed by the a 5 ☐ Other (specify) P.O. 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed been 24a. Was an autopsy performed. 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 certificate 2 □ No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 I Nursing Home After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 A Residence - 6 He ther (Specify) DWC | W 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation r death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1)396ic 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Køgert Deurt

31. Date filed (Month, Day,

Bultimore, MD

wint Point

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25,30 per dr.,g900,92/04/2010dnb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 01 John Benson 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bon Secour Hospital Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours 02/25/ Alabama 1936 Director 381-34-1364 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Willard Street 21223 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 🛮 Never Married 2 🗆 Married npleted by 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working

Physician/ Medical Examiner

attending physician and for use as the burial-transit ate has been signed by the page 2 should be detached

Division of Vital Records, P.O. Box 68760

S	Elementary/Seconday (0-12)	College (1-4 or 5+)	Truck Dri	ver	,	Trucking Co.						
Be	17. Father's Name (First, Middle, Las	st)		18. Mother's Name (Firs								
은	John D.	I	Benson	Anni	6	Harris						
	19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Karen English	(Daughter)	2910 Reisterstown Rd, Baltimore, MD 21215									
	20a. Method of Disposition	20b. F	Place of Disposition (Name of	Date		ocation - City or Town, State						
	1 Burial 2 XCremation 3 4 Donation 5 Other (Spe	ecify) And	yseph ^{ma} brown ^{pla} 1 Crematory	01/28/	10 Bal	timore,MD						
	21. Signature of Funeral Service Lice	7 N. Willia	Joseph 1 2140 N.	s of Facility H Brown J Fulton Av	r. Fune e.,Balt	eral Home imore,MD 21217						
	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	omplications that cause the death y one cause in each line.	n. Do not enter the mode of dyin	g, such as cardiac or resp Tuck uld	clu ben	Approximate Interval Between Onset and Death						
<u>.</u>	Sequentially list conditions. Due to (or a consequence of): Due to (or a consequence of): Due to (or a consequence of): Due to (or a consequence of):											
xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. Juli to (or as a consequ	c. Due to (or as a consequence of:									
dical E	resulting in death) Last Due to (or as a consequence of): Nesfwatory wywficianing flaunch effusion											
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											
ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the Inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown											
Complet	maj nututi	is Alba	tensem C.	7-//-	24a. Was an autopsy performed?	prior to completion of cause of						
Be	25. Was case referred to medical examiner?	Hospital:		ace of Death (Check only								
2	1 Yes 2 X No 27. Mann of Death	1/12 Inpatient 2 □	ER/Outpatient 3 DOA Other	4 U Nursing Home 5								
Certificate: To Be	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	t he		/ at ? Yes 2 □ No	Describe how injury	y occurred						
	4 ☐ Homicide determine	ed 28e. Place of Injury - At ho building, etc. (Specify,		C	City or Town, State							
Medical		hysician: To the best of my knowle miner. On the basis of examination urse Practicles: To the best of my	edge, death occured at the time and/or investigation, in my opinio knowledge, death occurred at the	date and place, and due in, death occurred at the ti e time, date and place, and	to the cause(s) an me, date and place I due to the cause(s	d manner as stated. , and due to the cause(s) and manner stated. s) and manner as stated.						
	29b. Signature and title of certifie	July Jano		License number 29d. Date signed (Month, Day, Year)								

Bon Secour Hospital, 2000 W. Baltimore St., Baltimore, MD

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person w

31. Date filed (Month

Jean Albert Midy,

park

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9900 2-18-10 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Burns Pauline 2010 February 5:19 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 5109 206–38-6109 8. Date of Birth (Month, Day, Yea Jan. 11, If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F 1942 New York 68 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No Maryland | Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20776 3878 Old Birdsville Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 ☐ Never Married 2 🔀 Married ☐ Yes 2 X No hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Lithography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Claude Bush permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Marie Lockwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3878 Old Birdsville Road, Harwood, Maryland 20776 Thomas A. Burns/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 3. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ned by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 Yes _ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Propatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work? 1 🗆 Yes 2 🗆 No Natural 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the fi 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Qertifying Nurse Practiquer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature ar certifier 29d. Date signed (Month, Day, Year) 30. Nam State Registrar

Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, end item 8 per in g900 2-16-10 vt amend item 7 per in g900 2-17-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day TAMES MAURILE 1428 M BROWN JAW 31 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner & Lumber ENERKL HOST HOW AR If Under 1 Year | If Under 24 Hrs. ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Bigth 1-9-38 **Funeral** Months 1**X** € 2 F Days Hours Min. Yrs. VIRGINIA Director 229-48-5543 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rral", or items 23a or 28a-f sl Exeminer naat be notified ELLICOTT 1XYes 2 No Director MD HOWARD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21043 7804 MAYFAIR CIRCLE US A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIRECTON OF TRANSPORTATION MILITARY 12. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN GRACE BEOWN ည of Health and Nitem 27 Is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLICOTT (1 FY MD 21045)
Date 20c. Locatfor - City or Town, State BROWN-WIFE 1804 MAYFAIR CIR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) o = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Good HOPE Ch CEM 2-6-2010 KING GEORGE, VA 4 ☐ Donation 5 ☐ Other (Specify) Puneral Service Lic 22. Name and Address of Facility HOWELL FUNERAL Hamis 21. Signature 10220 GUIL FORA, Rd. JESSUP, MIV WHE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ASYSTOL /Medical Due to (or as a consequence of): Examiner CARDICVASCUL APT BRUOSLEROTIC Sequentially list conditions, if any, leading to infine indecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and lee detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 ∐Yes 1 ☐Yes 2 ☐ No 2 **N**O 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 PER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident hours after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kuch D 25 Och JAN 31 2010 mp excen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARP CO GEN BRAL KUSP UMBLA mos 2104 LEVAN KUCK 31. Date filed (Month, Day, Year, Registrar's Signa State FER 0 4 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear 11-06A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death hmore 1 600 dita Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Hours 1 M 2 2 Months Days Min. May 24 1931 Mary Tand Yrs. Director 212**-**30-1593 Usual Residence of Decedent show 10a. State 10b. County iral", or items 23a or 28a-f sho filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Marvland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 864-A Nabbs Creek Road 21060 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker t. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, the Be **3altimore, Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Albert Muth Lillian Gertrude O'Donnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Bannan/ Son 5217 Windsor Mill Road Gwynn Oak, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Loudoun Park Cemetery 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility MacNabb Funeral Home. 301 Frederick Road Catonsville, Maryland 21228 Alice Iser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) en Medical Due to (or as a consequence of) Examiner Securifically list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 ×No 2 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 Tes 2 🗌 No Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koby + M Yaya 31. Date filed (Month, Day, Year) Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760

certificate has director. this funeral After Director:

၉

Certification:

Medical

State

Registrar

examiner?

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

1'XYes 2 No

within 24 hours To the Funeral

29b. Signature and title of certifier eput 29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 , certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

5 America Ct.

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

30/Name and address of person who complet cause of death (Item 23a) (Type, Print)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

1/1/ 32. Registrar's Signature

31. Date filed (Month, Day, Year, 4 0

5 ☐ Pending investigation

6 ☐ Could not be

determined

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day Year 5150 PM ,2010 Januar /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death l to If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** -3 1 X M 2 □ F Director March an Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercinar must be notified at Director Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 01 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐Yes 2 No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nion than " permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M Elementary/Secondary (0-12) College (1-4or 5+) UDICAR Therapida 1211 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Kirkcaldo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mace m. Clas 23a. P vt1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or he inhaliture. List only one cause on each line.

Immediate Cause if inal disease or condition resulting in death)

Due to (or us a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or/as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Por 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ᠒ Unknown director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 1 □ Yes 1 Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this eral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director; ≯ 1 □Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

FEB 0 4 2010

31. Date filed (Month, Day, Year)

Denve B. parket ORIGINAL

32. Registrar's Signature

H NOCEM MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUNIN NAFEM 501 DODD

DHMH 17 Rev 1/2001

10-00959 Colleen Brooks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 02945 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ 1338 hrs Medical Examiner February 2, 2010 Colleen Brooks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 6612 Marne Avenue **Baltimore** 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year Funeral Days Months Hours Min. Director August 3,1965 Maryland 215-86-5468 44 2X F Country) 1 M Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show Baltimore Maryland or items 23a or 28a-f sho must be notified at once, more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code ā 21224 U.S.A. 6622 Marne Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes If Yes, Give Year Specify: White 4 X Divorced Yes 2 X No specify: 3 Widowed ≦ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Company Elementary/Secondary (0-12) the Medical Chesapeake Telephone NA Operator 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ronald Brooks Claire Me]]11s 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter Joni Johnson 2 Maple Drive Apt. A. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State rebruary Baltimore, crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from Stat permit. Page:
Department o 5,2010 Bayview Crematory Inc Baltimore, Maryland Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dahrowski/Chojnacki Funeral Homes P.A. iniury ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Part I. Enter the disease, or complicate ailure. List only one cause on each ine een Onset and /Medical Death Methadone and alprazolam intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial 3a.27.28a-f per ME g902 4/6/10 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ signed be deta ğ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed this certificate has been il director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of perform<u>ed</u> death? 1 🗸 Yes ✓ Yes 2 No 2 No Hospital or Attending Physician: 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Other₄ Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No subject ingested methadone and 28a. Date of Injury (Month, Day, Year) After 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 1 Natural Division 1 Yes 2 X No Director: d in by the f Pending death Fd 2/2/10 Fd 1320 hrs alprazolam 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6612 Marne Ave Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street Could not be Suicide (Specify) residence determined 24 hours Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 7 Po I and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 3, 2010 refeted cause of death (Item 23a) 30. Name and ordress of person wh Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD Registrar's Signature 31. Date filed (Month, Day State OCME Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ORACE STERLING BRAUNING, VR 11,00 PM EB 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARK ROAD DEER FINKSBURG CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG-23 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1**X** M 2□ F 216 28 8723 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at CARROLL 1 ☐ Yes 2 No Director mo INKSBURG 10g. Citizen of What Country? 10e. Street and Number 2655 UEER 21048 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 1945 -If Yes, Give Year or Dates: 1949 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: WHITE 3 Widowed 4 Divorced 1949 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BAHTIRE Service. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) OWNER-SALESMAN 17. Father's Name (First, Middle, Last) S. BRAUNING, SR ANNA MATILDA LEISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PEGGY JEAN BRAUNING/WIFE 2655 DEER PARK ROAW FINKSBURG MO 21048 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5/2010 HNKSBURG, MD VERGREEN MEN GAR 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility | NZUMBUW FA & NOV & 60,29 SYKESVILLERO ELDERSBURGMO 21784 or polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one caus nset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760. attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to redical examiner? Be 26. Place of Death (Check only on Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes Certification: To Manual or L of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director; A
completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29d. Date signed Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State FEB 0 4

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mantal Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 2010 FEBRUARY **IRENE** BENESCH 12:09A [™] Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY Social Security Number 7. Age (In yrs, last birthday If Under 24 Hrs Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Birthpiac Country) MD 1 □ M 2 🗶 F Davs 07/23/1921 Director 212-12-9891 88 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 MONTROSE ROAD, #3131 20852 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 0 Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HARRY SACHS BESSIE **MEYER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY BENESCH / SON PERSHING DRIVE, SILVER SPRING, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW FRIENDSHIP 2/3/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Medical 10 DAYS PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Jause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 No 3 1 Propably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 X No of Vital Be 26. Place of Death (Check only one) Other: 1 X Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Division Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67986 2/2/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUNENG Li, 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Roger-Edgar Bo			and / Departm			d Mental F	lygiene	201	0 02948
		1- For State Registrar	Certific	ate of	Death			Reg. No.	
Physicia		Decedent's Name (First, Middle,Last)					2. Date of De Month	Day Year	3. Time of Death 0652 hrs
Medical Exami	iei	Roger-Edgar Bowman 4a. Facility Name (if not institution, give street and r	umber)	14	b City Town or	Location of Deaf	January 3	4c. County of Dea	
1		3420 Churchville Road			Aberdeen			Harford	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	thday)	If Under 1 Yea Months Day		n.	Fore	
Director		221–12–9266 1XM 2 F	86	Yrs.			May 2	6, 1923 °	CountryDelaware
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	on	· <u>·</u>			10d. Inside City Limits
≱ ,	اي	Maryland Harford	Aberd	doon					1 Yes 2 No
laryla 8a-f s	Directo	10e. Street and Number	1 AIREC	10011	10f, Zip Code			10g. Citizen of What Co	ountry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Heath and Mental Hygene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		3420 Churchville Rd.			21001	1		USA	
h with	eral	The first of the f	ecedent Ever in U.S. Forces?			spanic Origin? (\$ n, Mexican, Puert		o- 14. Race - Am White, etc.	erican Indian, Black,
or deat	Funer	1 Yes 3 Widowed 4 Divorced If Yes, Give You	2 x No	1	Yes 2 X No	snecify:		Specify: Whi	te
irs afte ural"	þ	15. Decedent's Education (Specify only highest gr.	ade completed) 16a.	Decedent	's Usual Occupa	tion (Give kind of		16b. Kind of Busines	
72 hou	etec	Elementary/Secondary (0-12) College	(1-4 or 5+)	during mo	ost of working life	. DO NOT use re	tired)		
036 rithin ene.	Completed	124		C	hemist			Governme	ent
5-00.	ပိ	17. Father's Name (First, Middle, Last)					•	Maiden Surname)	
and 2 should be filed within 72 hours aft and 2 should be filed within 72 hours afteath and Mental Pygiene. tem 27 is marked other than "natural" traumatic event, the Medical Examin	ω	Roy E. Bowman 19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Stree		E. Rog	e rs imber, City or Town, Sta	ite, Zip Code)
MD 2 tid 2 shou lith and N m 27 is n aumatic	ဥ	Bruce E. Bowman (son)	1.1	_	•			en, MD 2100	
ore, ML es l and 2 s of Health a If item 27		20a. Method of Disposition	20b. Place		tion (Name of ce		Date	20c. Location - City	
nore		1 Surial 2 Cremation 3 Removal 4 Donation 5 Other Specify:	IIOIII State	-		Gardens	2/5/10	Aberdeen,	Marvland
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		21. Signature of Tuneral Savins Licensee							
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Physician		23a. Part 1. Enter the disease, or complications that failure. List only one cause on each line.				, such as cardiac	or respiratory ai	rest, snock, or neart	Approximate Interval Between Onset and Death
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BO)	hysi	1 Yes 2 No 9 Unknown 9 Unk							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	þ	Part II. Other significant conditions contributing	to death but not resulting	ng in the u	nderlying cause	given in Part I.		tobacco use contribute es 2 No 3 Pi	robably 4 🗹 Unknown
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or At or At after d Direct	Certification:	3 Suicide 6 Could not be 28e Pl	ace of Injury - At home, f	farm, stree	et, factory, office i	building, etc.	28f. Location or Town,		Rural Route Number, City
Spital hours neral	Cer	4 Homicide determined (Specif					1		
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The I To the Funeral Director: After this certificate I completely filled in by the funeral director, page	edical	29a Certifier 1 Certifying Physician: To the body one) 2 Medical Examiner: On the basis	est of my knowledge, de s of examination and/or	eath occur investigat	red at th e time, d ion, in my opinio	iate and place, ar n, death occurred	at the time, dat	use(s) and manner as si e and place, and due to	the cause(s)
To I To I	Med	29b Signature and title of certifier			29c. Licens			29d. Date signed (A	
	172	Dame Hundrell	nah		O.C.	M.E.		January 31, 20	10
		30 Name and address of person who completed ca	use of death (Item 23a)						
		A 1	t Medical Examine			et, Baltimore,	MD 21201		
	tate	31. Date filed Weeth Day Yeard 2010 32.	Registrar's Signature	arko	1				
Regis	ueli	I LUU - CUIU COM							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day 2 2. Date of Death Physician CLEMENT J. BEVAN FEBRUARY 2010 10:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 8505 BASSETT ROAD ROSEDALE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 – 11 – 9. Birthplace (State or Foreign **Funeral ¾** M 2 □ F Months Days Hours PENNSYLVANIA 89 Director 165-12-3397 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, or all others in a must be notified at BALTIMORE ROSEDALE Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8505 BASSETT ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 XYes 2 □ No 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 1 ☐ Yes 2√2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE WWTT Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If fiem 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER BETHLEHAM STEEL 12 4 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) CLEMENT BEVAN REGINA (BYRNE) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERTRUDE L. BEVAN/WIFE 8505 BASSETT ROAD ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD 2-5-2010 CEMETERY PARKVILLE, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 160. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate perform 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 | Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours a

To the Funeral D

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person

DHMH 17 Rev 1/2001

ho completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

435593

1124 Mace Ane Batta

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 31, CRITES CROSS January 2010 7:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blakehurst Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1919 9. Birthplace (State or Foreign Country)
Mary Jand 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min. 1 🗆 M Director 216-14-7124 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 □Yes XX No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes X2X □ No Specify: White Specify: 3 X Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, the june Teacher Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Solomon Crites Beatrice Hark ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR Susan Cross Sellers 4170 Regency Drive Colorado Springs, Colorado 80906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💢 remation 3 Removal from State 4 Donation 5 □ Other (Specify) GreenMount Crematory 2/3/10 Baltimore, Maryland nature of Funeral Ser 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complex of the co s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lara disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ₺No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown been s 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 □Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 □ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

of Vital Records, P.O. Box 68760, Division

filed within 72 hours after death

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

/0

State Registrar

Medical

29a. Certifier

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

WaJOPPARD TOWSON NCRNP 1055

31. Date filed (Month, Day, FEB 0.4 201

10-00853 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cynthia Kaye Carter State of Maryland / Department of Health and Mental Hygiene 2010 02951 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cynthia Kaye Carter Medical Examiner 0136 hrs January 30, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 708 Meadowbrook Lane Catonsville **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 218-78-8719 Months Days Min. Director 1 M 2 X F Hours Feb. 19, 1969 Country) Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD N/ABaltimore 1 Yes 2X No s 23a or 28a-f show e notified at once. 28a-f show hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3111 Strickland Street 21229 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wir
Department of Health and Mental Hygione.
Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be a Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes If Yes, Give Year Divorced 1 Yes 2X No specify: White Specify: δ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John Dale Carter Charlotte Stoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas D. Ellis, Jr. - Son 4001 Colchester Street, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Atlantic Crematory 2-3-2010 Glen Burnie, MD Donation 5 Other Specify. 22 Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Listons 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interva failure. List only one cause on each line en Onset and /Medical Heroin intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a,27,28a-f,perm,E g900 2/18/10 TT attending physician or use as the burial -XUNPENDED Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be-IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No lınk death. Director: d in by the f 5 Pending 1/30/10 Fd 1:31 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)Fd: 708 Meadowbrook Ln. Catonsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 _ Suicide 6 X Could not be Found: private dwelling determined (Specify) the Hospital the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24] Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year)

N

State 31. Date filed (Month, Day, Year)
Registrar FEB 0 2010

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E

January 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 523 Physician/ Month *M Februer Third Medical ity Name (if not institution, give street ar City, Town, or Location of Death **Examiner** 4c. County of Death HOSD HA mor If Unde If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) March 8, 1938 1 M 2 D Months Hours Min. Gountry) Japan 214-74-9785 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the matural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3814 Biddison Lane 21206 U.SA. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 24 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: Asian Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danny Ciapura/ Son 3814 Biddison Lane, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cemetery 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 02/9/2010 Parkville, Maryland 4 Donation 5 Other (Specify) 21. Sign ure of Funeral Service Licensee Evans Furerally Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 2 a. P-rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s jock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) oronan Medical o (or as a conseque) ce of): Due Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ure and title of certifier 29d. Date signed (Month, Day, Year) H0068991 who completed cause of death (Item 23a) (Type, Print) 5 V

9 V

State Registrar 31. Date filed (Month, Day, Yea

fare

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EXPM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1423 Saint Christopher Court Edgewwod Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 10/30/1958 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Months Days 220-74-1669 52 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1423 Saint Christopher Court 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No White Specify. Specify 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Labor Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk William Dimeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Lou Lambert/Daughter <u> 1423 Saint Christopher Ct.,</u> Edgewood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/03/2010 | Hanover, Maryland Ardent CremationServices 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se y e Li ensee 22. Name and Address of Facility Ardent Cremation Services 7522 ConnelleyDrive,Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a onsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 1 Yes ≥ No 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

Physician /Medical Examiner certificate be executed and attending physician for use as the burial P.O. Box 68760

signed by the ar

certificate has been s irector, page 2 should

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records,

Physician

Examiner

Funeral

Director

show

Director

Funeral

A

Completed

Be

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MD

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Experiment must be redified at once.

and 2 should be filed within 72 hours after

Pages 1

Baltimore, Maryland 21215-0036

/Medical

Examine Physician/Medical δ Completed Be

P

Certification:

cal

3 Suicide

29a, Certifier

4 Homicide

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

> 1 Natural 2 Accident 5 Pending investigation

6 ☐ Could not be

Date of Injury (Month, Day, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

end manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 02954 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Mary Helen Dukes 0630 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death **Examiner** Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Country)
ent 22.1946Maryland Days Hours 214-44-4167 1 🗆 M 2 🖫 F Director 63 Usual Residence of Decedent items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director N/ABaltimore 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be once. 21223 2507 Hollins Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces þ 1 Never Married 2 Amarried SpecifyBlack ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Self Employed Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider <u>10th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Lena Henson Leslie Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2507 Hollins Street Baltimore, MD 21223 19a. Informant's Name/Relationship (Type, Print) Jerry D. Dukes/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 8/10 Cem. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest Vet 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 Signature of Funeral Service Licensee Vario Part /. Enter ty disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hely failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician/ Tletestic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been sinned by the Attendion Continued. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No g 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No 은 1 🗌 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the ft. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1, 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print) Union Memoril MD 31. Date filed Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 02955 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year LURMAN 10:00 AM 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WOODBRIDGE LANE CARROLL YKESVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAW 18 1912 5 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1**X**M 2□F Months Days Hours Min 88 216 14 7491 Usual Residence of Decedent 1922 MARYLAND 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo SYKESVILLE CARROLL mo 10e. Street and Number 10g. Citizen of What Country? USA 21784 WOODBRINGE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOY (), \$5, BODY SHOP 0 17. Father's Name (First, Middle, Last) DAMM MARGARET STIERHOFF WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SANORA DAMM- HAMBUN/DAL 80907 16 EAST WASHINGTON ST COLONADO SPRINGS, CO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) WINFIELD, MD 12010 21. Signature of Funeral Service Licensee VN ZUMBRU FHAMONGO 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ELDERSBURG-MO Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury d. Date of delivery Year Month Day e contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Physician /Medical Examiner

and

Department of Health a Important: If item 27 Is any Injury or other trau once.

Physician

/Medical

Director

Be Completed by Funeral

2

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Completed by Physician/Medical Examiner Be Medical Certification: To nours after death.

neral Director: After this filled in by the funeral di

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last	Due to (or as a consequent.	ence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Yea			
Part II. Other significant conditions co	ntributing to death but not resul	ting in the underlyin	g cause given in Part I,	23e. Did tobacco	use contribute to the cause of deat			
				24a. Was an autopsy performed?				
25. Was case referred to medical examiner?			26. Place of	Death (Check only one)				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	g Home 5 Residence	6 □Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	jury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify)	ne, farm, street, fac	28f. Location (Street a	 Location (Street and Number or Rural Route Number, City or Town, State) 				

State Registrar

DHMH 17 Rev 1/2001

To the Hospital o within 24 hours aft To the Funeral Di

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

MCEVOY

1380

32 Registrar's Signature

rogress

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

21784

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year Evelyn Eydelloth РМ 3:50 February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lutherville- Timonium Baltimore Stella Maris Hospice Center 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2XX February 20,1918 Months Hours Director 216-01-1745 91 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Harford Abingdon 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1449 Valley Forge Way 21009 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner , or , Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : within 72 hours after Maryland 21215-0036 White 1 Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) Elementary/Seconday (0-12) Housewife Own Home Be 2010 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Joseph Winson Cecelia Winson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1584 Eaton Way, Annapolis, Maryland 21401 Page 1 and 2 Sherry Ceccarelli Daughter Baltimore, FEBRUARY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February Dundalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8, 2010 21. Si veture of Faveral Service L 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition END STAGE CARDIAC DISEASE Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 Hospital or Attending Physician; The law requires that the death certificate attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death EYDELLOTH 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Day the page 2 should be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed Completed by Records, No 3 Probably 4 Unknown EVELYN . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, X Natural 5 Pending work? 1 Yes 2 No Investigation Accident the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Number Practionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F fall the filme, date and place, and due to the cause(s) and manner as state the only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

30. Name and

JACKTE JONES, CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ss of berson who completed cause of death (Item 23a) (Type, Print)

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \, \cap$ 02957 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:42A M ERAUGH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Linthicum Tate Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** 1 M 2 F 9/19/1918 91 Mary and 215-03-8273 **Director** Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Columbia Howard 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9101 Gracious End Court Apt 104 USA 21046 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XX No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Ruck Funeral Home, Inc Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname)
Marie Dugge 17. Father's Name (First, Middle, Last) ည Arthur House ^{19a.} Informant's Name/Relationship (*Type Print*) Carolyn Zimmerman / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21048 6679 Drowsy Day 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Parkwood Cemetery 1 X Burial 2 Cremation 3 Removal from State 2/5/2010 |Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility TOWSON, Maryland 21204 Signature of a Se Ruck Towson Funeral Home, Inc. 1050 York Road Mehal 23a. Part 1. Enter the dise so or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Other (specify) Pregnant at time of death jed the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **XV**No ျပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar Annapolis, MD 21401

30. Name and address of person who completed dause of death (Item 23a) (Type, Prik

RIEGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10ccf Per FH G900 2/04/2010 IH
State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D FEBRUAR Physician/ 04:00AM Medical 4a. Facility Name (if not institution, give street and num 4b. City, Town, or Location of Death 46. County of Death Examiner CARROLL WESTMINSTER DOVE HOUSE 9. Birthplace (State or Foreign Country) MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 🗆 M 2 🗷 F Months 0870471993 18-39-7235 Yrs Director 16 Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director WESTMINSTER Finksburg 1 Yes 2 X No CARROLL MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21048 USA 21157 2993 KENSHAW DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc 1 🕅 Never Married 2 🗆 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT **EDUCATION** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ ROTHSCHILD **ESTEY** JOANNE DAVID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2993 KENSHAW DRIVE, FINKSBURG, MD 21048 JOANNE EISENSTADT / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2/3/2010 BALTIMORE HEBREW CONG REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause n e on line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner Sequentially list conditions, Examine ri any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of signed by the attending physician and is be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral circctor, page 2 should be detached for use as the burn of the funeral circctor, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 - No 1 🗌 Yes Be 25, Was case referred to medical 26. Place of Death (Check only one) examiner? Leve Other: 4 Nursing Home 5 Residence 6 other (Specific 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 \square Pending Natural 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Getting Prijabilism. To the basis of examination and/or investigation, in my opinion, death procurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one nd title of certifier 29b. Signatur 29c. License numbe 29d. Date signed (Month, Day, Year) State FEB 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 02959 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January Mary Francis France 2010 1:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8930 Old Frederick Rd. Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🗓 F 213-28-6231 $\operatorname{February}^{Month, Day, Year)} 1932$ Maryland Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8930 Old Frederick Rd. 21043-1926 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Alfred Sellers Francis Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8930 Old Frederick Rd. James France/son Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Good Shepherd Cemetery Feb. 2,2010 Ellicott City, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore. MD 21212. While O. Mitchell 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1 monary disease or condition resulting in death) nronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 WNo
9 Unknown Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours aft

To the Funeral Di

completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my position, death occurred at the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D681 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

10-00985
Michael Forte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar Reg. No.										02961	
Physici	an/	Decedent's Name (First, Midd	fle,Last)	2. Date of De Month		Year		3. Time of Death 0332 hrs					
Medical Exami	ner	Michael 4a. Facility Name (if not institution	on give street and nu	Fort		o. City, Town,	or Location	n of Death	Month February		010 Ic. County of	Death	0332 1118
		2805 Page Drive	on, give street and no	niber)		Dundalk	OI LOCATION	TO Death	Baltimore Co				nty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Y	ear If Un	der 24Hrs.	8. Date of B	irth (MN	WDD/YYYY)		nplace (State or Foreign
Director		216-90-7493	1XM 2F		44 Yrs.	Months D	ays Hou	ırs Min.	Min. April 17,1965 Maryland				
		Usual Residence of Decedent										\equiv	
w any		10a. State 10b. County		10c. City,	Town or Locatio								10d. Inside City Limits 1 Yes 2 XNo
Aaryland 28a-f show 1 at once.	ķ	Maryland Balt 10e. Street and Number	imore		Du	ndalk 10f. Zip Code				10a Ci	tizen of Wha	at Cour	
te Mar or 28s	Director	2805 Page Driv	re				222			rog. G	USA	it cours	uy.
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner, myst be notified at once		11. Marital Status		edent Ever in U.S	S. 13. Was			rigin? (Sp	ecify Yes or N	0-		Americ	an Indian, Black,
death r item	uneral	1 Never Married 2 M	Married Armed Fo	rces?	If Yes	s, specify Cub	an, Mexica	an, Puerto I	Rican, etc.)		White,	etc.	
after	by F		vorced If Yes, Give Year or Dates:			Yes 2∑ I					Specify:		
hours 'natu	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Decedent's during mos	s Usual Dccup st of working I				16b.	Kind of Busi	iness/In	ndustry
5-0036 led within 72 hours a tygiene. other than "natura the Medical Examin	ble	12 years	College (1	-4 O(5+)	Truc	c Drive	er			Tı	ranspo	rta	tion
5-00 ed wit flygien other	To Be Completed	17. Father's Name (First, Middle	, Last)				18.Moth	er's Name	(First, Middle,	Maider	n Surname)		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than													
D 2 should and Ma is ma		19a. Informant's Name/Relations Roseann Phelps		er		·					=		
re, MD s 1 and 2 sho of Health and If item 27 is	- 1	20a. Method of Disposition			1203 J			T	Dunda.		Maryla . Location - 0		21222 Town, State
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and Important: If item 27 is r njury or other traumaric		1 Burial 2 Tremation		All State	rematory or other		CS 7		ruary 2010	ח	-1++ma		Maryland
Baltimo permit. Page Department of Important:	- 1	4 Donation 5 Other S 2 Sunature of Funeral Service	pecify:	Da			***						
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Physician		23a. Part I. Enter the disease, or failure. List only one cause	r complications that ca	used the death	o not enter the	mode of dyir	ng, such as	cardiac or	respiratory ar	rest, sh	ock, or hear	t	Approximate Interval Between Onset and
Examiner	- 1	Immediate Cause (Final disease	a Oxyjco			1 into	xicat	ion					Death
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	욘	1 Yes 2 No 27. Manner of Death			ER/Outpatient 28b. Time of Inju		jury at Wor		Home 5 28d, Describe		ence 6 🗸		Scene
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To the Hos within 24 h	Medical		miner: On the basis o and manner st	f examination an ated.	id/or investigatio				the time, date				
	2	29b. Signature and title of certific		7			nse numbe C.M.E.				bruary 3, 2		h, Day, Year)
		30. Name and address of person	who completed carre	of death (Itom)	239)					1.0			
		Russell Alexander ME		-		enn Stree	et, Baltim	ore, MD	21201				
	_	31. Date filed (Month, Day, Year)	- for	gistrar's Signatur	. for	1.1							
Regist	rar	FFDAA	2010 /201	ma B	· Marian	TO THE REAL PROPERTY.							

			For State Registrar	State of Mar		/giene Reg. No. 2010 0296					
· ·	Physici /Medio	al	1. Decedent's Name (First, Middle,	chard Patrick	Fisher,	1	u Leastion of Death	2. Date of Death Month Jan.	Day Year 31 2010 4c. County of Dea	3. Time of Death 8:15 P	
	Examin Funeral Director	er	4a. Facility Name (If not institution, 838 Staffordsh 5. Social Security Number 201–24–6798	ire Rd.	(In yrs. last birthday) 9 Yrs.		ysville If Under 24 Hrs. Hours Min.		Baltimo		
	ъ	ector	Usual Residence of Decedent 10a. State 10b. County MD Baltii		Cockey				lg. Citizen of What C	10d. Inside City Limits 1 □Yes 2 □₩o	
	ath with t	Funeral Director	10e. Street and Number 838 Staffordsh				21030		USA		
9800	72 hours atter death with the Maryland 'ratural', or items 23a or 28a-f show diest Experies to cities at		11. Marital Status 1 □ Never Married 2 ★ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? ed 1 MYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 XNo	Hispanic Origin? (S an, Mexican, Puert Specify:			vhite	
21215-0036	within 72 hu iene. than "natu he Medical	Completed by	15. Decedent' (Specify only highes) Elementary/Secondary (0-12)	t grade completed) College_(1-4or 5+)	(Give	DO NOT use retire	during most of wor		6b. Kind of Business Education	-	
	be filed ntal Hyg ed other event,	To Be Cor	12 17. Father's Name (First, Middle, L Richard Franci		Teac	cner	1	ne (First, Middle, Ma etta McG	aiden Surname)		
Maryland	alth 27 I	Ĕ	19a. Informant's Name/Relationsh Grethen S. F						City or Town, State,		
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2' any injury or other once.		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Sign of a of Fine bifarvice)	ice see	Dulaney L	matory or other pla Valley M 2. Name and Addre emmon Fu	Memorial ess of Facility uneral Ho	Gardens	Timonium Janey Val ium, MD	n, MD Hey, Inc.	
-	Physician /Medical Examiner		23a. Part 1. F ter the d sease, or shock, it heart f lure. List of limmediate lause (Final disease or con "it" resulting in death)	-a. Metasto			ing, such as cardiad			Approximate Interval Between Onset and Death	
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O. Box	death certifi e attending d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□ Ectopic pregnan □ Other (specify) _	су		23d. Date of delivery Month Day Year		
σ.	w requires that the been signed by th should be detache	þ	Part II. Other significant conditio	ns contributing to death but	not resulting in the u	underlying cause gi	ven in Part I.			to the cause of death? Probably 4 Unknown	
of Vital Records,	Physician: The law re this certificate has be ral director, page 2 sho	Be Completed	25. Was case referred medical examiner?	Hospital:			har [,]	24a. Was an autopsy perform 1 □ Yes 2	rmed? prior to completion of cause of death? 2 □ No 1 □ Yes 2 □ No		
Division of \	al or Attending Physicater death. I Director: After this of an by the funeral directions.	ertification: To	1 Yes 2 No 27. Manne Death 1 Natural 5 Pending investig 2 Accident investig 3 Suicide 6 Could n determi	28a. Date of Injury (Month, Day,	year) 28b. Time of Injury y - At home, farm, st (Specify)	of 28c. Inju	nce 6 Other (Sp w injury occurred reet and Number or F , State)	,,			

To the Hospital or Attending Physician: The is within 24 hours after death.

To the Funeral Director: After this certificate he completely filled in by the funeral director, page.

Medical

State Registrar

31. Date filed (Month, Day, Year) FEB 04 2010

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

10-00936 Charles Futty

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

les Futty		- For State Of Maryland / Department of Fleath and Wernary - For State Certificate of Death	Reg. No.									
	F	tegistrar 1. Decedent's Name (First, Middle,Last)	Date of Death 3. Time of Death									
Physicia ີal Examir		Charles Jason Futty	February 1, 2010 2333 1115									
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	ath 4c. County of Death Harford									
		Old Philadelphia Road and Sickle Lane Aberdeen										
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours M	Aio Foreign									
Director	1	218-08-9448 1 M 2 F 24 Yrs.	June 25, 1985 Country) Maryland									
	t	Usual Residence of Decedent	10d. Inside City Limits									
v any		Toa. State	1 Yes 2 XX No									
Maryland 28a-f show d at once.	ă	Maryland Harford Havre de Grace	10g. Citizen of What Country?									
Maryl 28a-	Director	10e. Street and Number	ric)									
death with the Maryland or items 23a or 28a-f sho		318 Darlington Road 21078 11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (USA (Specify Yes or No- 14. Race - American Indian, Black,									
th wit	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)									
er dea		3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify: White									
2 hours after "natural", Examiner	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b. Kind of Business/Industry retired)									
72 hou "mai	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	service station									
5-0036 Iled within 7/ Hygiene. I other than	mpl	12 1 service attendant	ame (First, Middle, Maiden Surname)									
5-00 led wit Hygien other	၁	17. Father's Name (First, Middle, Last)	Liest Sarah Ann West									
21215-003 uld be filed with Mental Hygiene marked other t	Be	Charles Keith Futty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)									
D 21 should and Mer is man	2	19a. Illiothalics Halloritolation on (1) p-1	d. Havre de Grace, MD 21078									
Fre, MD 21215-0036 s. I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the <u>Medical Examiner must be notified at once</u>		20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State									
	1	1 XXBurial 2 Cremation 3 Removal from State	2/8/10 Aberdeen, Maryland									
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: HATTOR MEIROT IAI GATUERS 21. Signature of Funer Seniger incensee 22. Name and Address of Facility	larring Cargo Funeral Home. P.A.									
Baltimore permit. Pages 1 Department of Finportant: If important: If injury or other		Aberdeen, Maryla	Carring-Cargo Funeral Home, P.A. and 21001 Approximate Interval									
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinative. List only one cause on each line.	iac or respiratory arrest, shock, or heart Approximate interval Between Onset and Death									
/Medical	1	Immediate Cause (Final disease a Multiple Injuries	Death									
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O, e be e ysicia burial	ledical	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery									
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Bc he dea	ا چ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?									
ires that the signed by	2	l e e e e e e e e e e e e e e e e e e e	1 Yes 2 No 3 Probably 4 Unknown									
ords, I	Completed		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of									
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tal Rec sian: The certificate	<u>ק</u>	26.Place of Death (Cl										
/ital ysician: nis certif	2	25 Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 N	Nursing Home 5 Residence 6 🗸 Other: Scene									
- E = -	d F	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Pedestrian struck by a motor vehicle									
on of nding Pl th.	tion and	1 Natural 5 Pending Feb 1, 2010 2347 hrs 1 Yes 2 ✔ N	NO									
Division tal or Attendi	60 1	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Div ital or ral Div	Tilled in by the lune	3 Suicide 6 Could not be determined (Specify) Local Street	Old Philadelphia Road and Sickle Lane, Aberdeen, MD									
Hosp 24 hou Fune	oletely fi		e, and due to the cause(s) and manner as stated urred at the time, date and place, and due to the cause(s)									
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	completely	and manner stated.	29d. Date signed (Month, Day, Year)									
- 3-		29b. Signature and title of certifier O.C.M.E.	February 2, 2010									
		Funish Theil (M)										
		30. Name and address of person who completed cause of death (Item 23a) Parnela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201									
		Fairness E. Southail, W.S.										
Rec	Sta	EED A 2010 2										

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 01.0) Physician 2010 JANHER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖔 F 216-74-3133 Feb. 21, 1960 49 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location or 28a-f show Examiner must be notified at XXYes 2 □ No MD N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code with 21213 USA 1820 N. Chester St. or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ XNo Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo þ Specify: 3 Widowed 4 Divorced Black Year or Dates "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medicai (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. Housing Authority Administrative Asst. 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie O'dell Starks Cornelius James, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1820 N. Chester St. Baltimore, MD 21213 Kerry Gardner, Sr./Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. 2/8/10 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 21. Signature of Funeral Service Licensee 5 4210 Belair Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 \subseteq Live birth 2 \subseteq Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 XNO 2 NO No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 ☐ No Hospital: 1

Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ER/Outpatient 3 DOA မ I Director: After this ad in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident death. Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide after e Funeral Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ciol of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

		,	For State Registrar	State of Maryla		artment of F <i>rtificate of</i> I		1ental Hy	gienę Reg. Nd		02964			
	Physici	an	1. Decedent's Name (First, Middle, La	L.	G	ardner		2. Date of De Month Janua	Day	y 30,2010	3. Time of Death 12:27a M			
-	/Medio		Doris 4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of Death	Danua	4c.	County of Death				
, J.	Funeral				rs. last birthday,	Olney If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Did 3 – 0 6 –	-41-	ontgome 9. Birth Cou	ry Co. place (State or Foreig ntry) hington,			
	Director		Usual Residence of Decedent					3-00-	1 / 2					
	arylan show	r	10a. State 10b. County		City, Town or Lo				10d. Inside City Li 1-					
	the Ma 28a-f	ectc	DC 10e, Street and Number		Washir	10f. Zip Code			10g. Cit	21				
	with 3a or		1310 Vermont	Avenue NW		200	0.9		-	U.S.A.				
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Maritel Examination to each.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: R]	etc.			
21215-0036	thin 72 hou ne. ian "natura I Madical E	Completed	15. Decedent's Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a. Dece (Give life.		during most of work	ing		ind of Business/Ir				
121	led wii lygien her th	Cou	9th	4)		Clerica	18. Mother's Name	- (First Middle		C. Gene	ral			
Maryland	d be fi	Be c	17. Father's Name (First, Middle, Las	" Honesty			Virgi	, ,	, maiden	Bail	AV			
Z	should nd Me mark imatic	၉	Percy 19a. Informant's Name/Relationship			ng Address (Street	and Number or Rur		er, City o					
	nd 2 salth ar 27 is sr trau	١.,	Evelyn Roberts			-					DC 2001			
Baltimore,	Pages 1 aument of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 🖟 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Tricinovariioni cialo	. Place of Disp	osition (Name of		Date	20c. Lo	ocation - City or T	own, State			
Balt	permit. Depart Import any Inj	Ü	21. Signature of Funeral Service Lice	endee T			^{ss of Facility} Roi orth Ave				uneral H			
-	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that a used the de y one cause on each line. a. Due to (or as a cons	DIAB	ETES		or respiratory a	arrest,		Approximate Interval Between Onset and Death			
68760,		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	THRON	nBOCY	PENI	P		ŝŧ				
P.O. Box 687	or Attending Physician: The law requires that the death certificate be executed tree death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions	23c. If yes, outcome of precipitation and the control of the contr	etal death 3 of death 5	☐ Ectopic pregnanc ☐ Other (specify) _		23e. Did	tobacco	23d. Date of delivery Month Day Year pacco use contribute to the cause of death?				
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of Vital Records,	sician: The law requir certificate has been s rector, page 2 should	Completed						24a. Was auto perf 1 ∐Yes		l death?	copsy findings available ompletion of cause of			
/ita	cian: ertific	Be C	25. Was case referred to medical examiner?	Hamilali		Tout	26. Place of Deat	h (Check only	one)					
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	Mith Voit Com	Z	29b. Signature and title of certifler	e r	1 D.	29c. Licens	7313		29d. Da	ate signed (Month	20(0			
À	Y /		30. Name and address of person who MTUL AAVE 31. Date filed (Month, Day, Year)	completed cause of death (I	herso	Print) dvi	ve, Elli	colt ce	fy /	mo 21	042			
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arol Gabinet	1	State of Maryland / Department - For State Certificate			2010 a. No.	02965							
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2 Date of Death		3. Time of Death							
	ner	Carol Helen Gabinet		Month January 31		1316 hrs							
		4a. Facility Name (if not institution, give street and number) Harford Memorial Hospital	4b. City, Town, or Location of Death Havre de Grace	n	4c. County of Death Harford								
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 155-42-3745 1 M 2 X F 62) If Under 1 Year If Under 24Hr Months Days Hours Mir	_	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Camden, Country) N.J.								
è	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		Т	10d. Inside City Limits							
Aaryland 28a-f show any Lat once.	ō		de Grace			1 Yes 2 No							
ath with the Maryland irems 23a or 28a-f sho ist be notified at once	Ø.	10e. Street and Number 910 Arthur Road	10f. Zip Code 21078	10	g. Citizen of What Coun United St	-							
with t	_	Armed Foresco	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ White, etc.	can Indian, Black,							
9 P E	y Funera	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 No specify:	y risan, sio.,	Specify: Wh:	ite							
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d with	E O	12 05 17. Father's Name (First, Middle, Last)		e (First, Middle, M									
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	å	Anthony Adomaitis		eve Domzalski									
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imore, MD 2 Pages 1 and 2 shou ment of Health and A mant: If item 27 is n or other traumatic	-	20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery,	Date	20c. Location - City or	Town, State							
nor6		1 Burial 2 Cremation 3 Removal from State crematory or other place) Feb. 05, 4 Donation 5 Nother Specify Entanbrent Moreland Memorial Park 2010 Parkville, I											
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	- 1	21. Signature of Funeral Service Ligensee Jeffrey L. Gair, Sr.	2. Name and Address of Facility Peaceful Alternati 2325 York Road	ves Fune Timonium	eral&Cremat Maryland								
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		Sequentially list conditions, b.											
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6876 ertificate ding phy	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1											
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. The thin the Funeral Director: After this certificate has been signed by the attending physician pletely filled in by the funeral director, page 2 should be detached for use as the buring.	ρ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	bacco use contribute to	p							
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To the Hospita within 24 hours To the Funeral completely fille		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of (Check only one) Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, ar stigation, in my opinion, death occurred	nd due to the cause at the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)							
To the within To the Comple	Medical	29b Stanature and title of certifier	29c. License number		29d. Date signed (Mo								
		Meter Saller Jeck	O.C.M.E.		February 1, 2010)							
6		30. Name and address of person who completed cause of death (Item 23a)	I1 Penn Street, Baltimore, MI	21201									
XV V	toto												
S Regis	tate	FFR 0 4 2010 Page 1	arke										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Mary		epartme <i>Certifica</i>				1ental Hy	/giene Reg. No	2111	0	02966	5
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	Examin			If not institution, give	1	umber)		1	ty, Town, o		of Death		4c.	County of n/a			
			5. Social Security N	5 HOSpit		7. Age (In	yrs. last birt	hday) If Und	timos ler 1 Year		er 24 Hrs.	8. Date of B	irth			ace (State or Foreign	n n
	Funeral Director		218-26-		1 □ M 2 🌠 F	80		Yrs. Month	s Days	Hours	Min.	(Month, D	ay, Year)			ry) sylvania	
	TO		Usual Residence o								1					d. Inside City Limits	_
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	the M	Director	10e, Street and Nu				Catons		Zip Code				10a. Cit	tizen of Wh	at Count	- 11	
	with with	Ö		den Choic	e Lane				21228	3				USA		,	
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pu		Be C	17. Father's Name	(First, Middle, Last	")					18. Mot	her's Name	e (First, Middl	e, Maiden	aiden Surname)			
<u>ylaı</u>	ould b Ment arked aric e	욘	Albert (Albert Olsen Rosam													
Maryland	2 sh∉ hand risma raum			Name/Relationship				Mailing Addre									
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nor	Pages lent of nt: If it ry or o		1 X Burial 2	☐ Cremation 3 ☐ 5 ☐ Other (Speci		n State I		y, crematory o hn's C			2/2/	2010	. בונים ווים	icott	C++.	v, Marvla	
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	/Medical Examiner		resulting in death,		Due to	o (or as a co											
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¿ ou	Attending r death. ector: After y the fune	ţ	1 Natural	5 Pending investigation	(Mo	onth, Day, Ye.	ar) li	njury M	28c. Inju Wo	rk?]Yes 2[□No	EGG. BOSSIID	o non inje	ny occurre			
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Sterner, Division	tal or s afte al Dire	Certification: To	4 Homicide		Dulli	ding, etc. (S	респу)					City of T	own, Stat	e)			
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	the h	Medical	one)	d title of cortifier	and ma	nner stated.			29c. Licen	se numbe	ır		20d D	ate signed	(Month i	Day Year)	_
	6	_	29b. Signature and	#1)							-		-	
	BY		30 Name and add	dress of person who	completed car	use of death	(Item 23a)		DU03	284	7		Van	vary	30	2010	
)'		South	en evn	STAEN	es H	mite	1 900	Cato	n A	enve	Rel	Amo	no 1	Jan	lant	
	Sta		31. Date filed (Mo	nth, Day, Year)	32.	Pegistrar's	Signature	park	1								
	Registr	rar		FEB 0 4 2	U10 \	Lucia	p.	grane									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ _Month 2016 1:24 AM ebrian Medical 4a. Facility Name (if not institution, **Examiner** City, Town, or Location of Death 4c. County of Deap 8 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) ate of Birth 9. Birthplace (State or Foreign **Funeral** 1 №M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at City. Town or Location 10a. Stațe Director 10d. Inside City Limits 72 hours after death with the Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. torcemen Be Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) mber or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traus Harris Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Deurial 2 Cremation 3 Removal from State cemetery, crematory or other 12010 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final blee Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine frank, leading to in medicause. Enter Underlying Cause (Disease or iinjury Ditte to for as a consequence of or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) ieral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Dio 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 **N**0 f 🗹 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 \square Pending 1 Tes 2 No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar SANJAY

31. Date filed (Month, Day, Year)

FFR 0 4

MUNIZEDD

gistrar's Signature

Bultimore

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month 2 Day Year taroldyn /Medical 2010 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlestown Care Center Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours Director 534-18-9989 97 Feb. 28, 1912 Minnesota Usual Residence of Decedent with the Maryland show 10c. City, Town or Location 10b. County 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla cartment of Heath and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 709 Maiden Choice Lane RGS 212 21228 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Tyes 2 X No. Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **5+** Administrator Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Lober Minnie 2 Toraason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Kelly/ Daughter 530 Second Street, Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 4, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Signature of Juneral Service Licenses Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** As piration / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day 5 Other (specify) P.0. 1 Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Stage Demen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Dysphag 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2

Division or Vital To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 22/10 Other: 4 Nursing Home 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

29b. Signature and title of certifier

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

2/228

2:450M

1 ☐ Yes 2 No

Year

State Registrar

Certification:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

uth Head		1- For State Registrar	State of Maryla	-		of Health ar o <i>f Death</i>	nd Mental I		201	0 0 2 9 6 9			
Physicia Medical Examin	n/	Decedent's Name (First, Michael Control of the	ddle,Last) Iead			-		2. Date of Death Month February 1	Day Year	3. Time of Death 0005 hrs			
Tedical Exami		4a. Facility Name (if not institu	tion, give street and nu	ımber)			or Location of Dea		4c. County of Dea	th			
^		Saint Agnes Hospita	l 6. Sex	7. Age (In yrs. I	ast hirthday\	Baltimore If Under 1 Ye	ear If Under 24H	Irs 8 Date of Birth	N/A n(MM/DD/YYYY) 9. B	irthplace (State or			
Funeral Director		5. Social Security Number 212–26–3287	1 M 2 X F	83		Months Da		11/05/1	Fore				
any	ŀ	Usual Residence of Decedent 10a. State 10b. Count	ly	10c. City,	Town or Loc	cation			-	10d. Inside City Limits			
*	٦	Maryland Balt	imore	С	atonsv	ille				1 Yes 2 XNo			
th the Maryland 23a or 28a-f show notified at once.	~ L	10e. Street and Number				10f. Zip Code		1	g. Citizen of What Co				
ith the 23a or notifie	a D	11 N. Hilltop		cedent Ever in U	S 13 V	212.		Specify Yes or No-	l 14. Race - Ame	erican Indian, 8lack,			
72 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral		Married Armed F			f Yes, specify Cuba			White, etc.	,			
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5-0036 led within 72 hours a tygiene. other than "natura the Medical Exami	Completed		1		Bus	siness Ow		(First Baidelle Ba	Graphic	Design_			
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ID 2121 should be fi and Mental 17 is marked natic event,		19a. Informant's Name/Relatio			Ti.	,	eet and Number o	or Rural Route Num	ber, City or Town, Sta	te, Zip Code)			
aur 2 aur 2	ŀ	Jeanne M. Hold	ien/ Daugni			Thackery position (Name of c		catonsv ruary 2,	ille, Mary 20c. Location - City of	Tand 21228 or Town, State			
nore		1 Burial 2 Cremat 4 Donation 5 Other		IOIII State	crematory or	other place) rematory,		2010	Baltimore	, Maryland			
Baltimore, permit. Pages 1 as Department of He Important: If ite	ŀ	4 Donation 5 Other 21. Signature of Funeral Servi	ce Licensee Amano	la Heast	on 22	. Name and Addre	ess of FacilitCre		ociety of	Maryland, In			
	-	23a. Part I. Enter the disease,	or complications that of	caused the death	. Do not ente	99 Freder or the mode of dying	cick Road	l, Baltime	ore, Maryl st, shock, or heart	Approximate Interval			
Physician		failure. List only one cau Immediate Cause (Final disea	se on each line.							Between Onset and Death			
Examiner		or condition resulting in death		a consequence o									
	اقِ	Sequentially list conditions, if any, leading to immediate		a consequence o	rf):								
	Examin	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
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6 be ex ysician burial	ledical	UNPENDED	AMENDED	outcome of preg	inanov.				23d. Date of delive	erv			
Ox 6876 eath certificate eath certificate eath certificate for use as the l	an/N	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	1 Live		2	Fetal death 3	B Ectopic preg	gnancy	Month	Day Year			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	1 Yes 2 ✓ No 9 U	Jnknown 9 Unkn		5	Other (Specify)							
P.O. I es that the igned by the	by Ph	Part II. Other significant con	ditions contributing t	o death but not r	esulting in th	e underlying cause	e given in Part I.	23e, Did tol	bacco use contribute t	o the cause of death? obably 4 Unknown			
ords, Pw requires to be sign should be or		i	······································					24a. Was a	in 24b. Were a	autopsy findings available			
Division of Vital Records, tal or Attending Physician: The law require its after death all Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	C						autops	m <u>ed</u> ? death?	completion of cause of Yes 2 No			
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To the Hos within 24 h Completely	Medical	(Check only	Physician: To the be examiner:On the basis and manner	of examination a									
25 ½ ½ S	₹	29b. Signature and title of cert		siated.	_		nse number		29d Date signed (M				
		unesc			- 02-1	0.0	C.M.E.		February 1, 201	10			
		30. Name and address of pers Ana Rubio MD. A	son who completed cau ssistant Medical			Street, Baltin	nore, MD 212	201					
St Regist	ate	31. Date filed (Month, Day, Yea		tegistrar's Signat	ye L	wed .							
313116		1 6.13 1 7	CHILL V. Wat	IMAGE !	W. 197 ()								

10-00899 John Charles Head Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 31, 2010 2359 hrs Medical Examiner John C. Head 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N/A Saint Agnes Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or 5. Social Security Number 6 Sex **Funeral** Foreign Mary Land Months Davs Hours Min. 12/04/1948 Director 61 214-56-0803 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No **Baltimore** Catonsville 'natural", or items 23a or 28a-f show Examiner must be notified at once. Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 United States 11 N. Hilltop Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 Married 2 X No Yes If Yes, Give Year Yes 2X No specify: Specify: White 4 X Divorced 3 Widowed ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail/ Wholesale Sales 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Ruth 0. Hess С. Head George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ೭ 19a. Informant's Name/Relationship (Type, Print) B Catonsville, Maryland 21228 Jeanne M. Holden/ Sister 303 Thackery Avenue, 20c. Location - City or Town, State February 2. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 8urial 2 X Cremation 3 Removal from State Baltimore, Maryland 2010 Metro Crematory, Inc. Donation 5 Other Specify. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** tween Onset and failure. List only one cause on each line /Medical Death a. Smoke inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical UNPENDED g physician a AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Day Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P. O. Completed by 1 Yes 2 No 3 Probably 4 V Unknown Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy . death? performed Yes 2 V No certificate l 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Involved in house fire FOLIND Natural 1 Yes 2 ✓ No 5 Pending Jan 31, 2010 2350 hrs 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide (Specify) Single Family 11 North Hilltop Road , Catonsville, MD within 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier (live February 1, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 32. Registrar's Signature State Registra

OCME

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Herbert	Huggins	Jr	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 0 297 | State of Maryland / Department of Health and Mental Hygiene

		For State		•		Certific	ate of	Dea	th			Re	eg. No.			
Physician/		Decedent's Name (First, Middl	e,Last)								2	Date of Deat Month	h Day	Year		3. Time of Death
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Funeral Director		Social Security Number 212 46 1731	6. Sex	2 F	7. Age (In	yrs. last bii 7	thday) Yrs.	If Und	hs Days	If Unde Hours	_	8. Date of Bir June		7.4	Foreign	nplace (State or n nWA
	U	sual Residence of Decedent														10d. Inside City Limits
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or ite	<u> </u>	*	arried 1	Yes es, Give Year	2X	No			2 x No					pecify: B	1720	sk
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21215-00 ould be filed with I Mental Hygien is marked other ic event, the Ms		Herbert F			Sr.	146	Oh Mailing	Addros	10 (011	and Alice		y Ave			Stata	Zin Codo)
O de de la fai		Thomas Huggi			her											21202
	20	0a. Method of Disposition				20b. Place	of Disposi		ame of ceme	etery,		Date 15, 201	20c. Lo	cation - (City or 7	Town, State
nor ages ant of nt: If		Burial 2 Cremation Onation 5 Other S		Removal fro	n State		dlaw				Feb	$\frac{6,20}{}$	© Bal	to.	Co,	, Md.
Baltimore, permit. Pages 1 at Department of He. Important: If ite injury or other tr		nature of Funeral Service		1/			22. N	ame an	d Address o	of Facility	ruga	s Fun	eral	НС	me	
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Physician /Medical	23	3a. Part I. Enter the disease, or failure. List only one cause	on each I	tions that ca ine.	uelid the o	death. Do r	not enter th	ne mode	of dying, s	uch as ca	ardiac or r	espiratory arr	est, snock	., or near	π	Approximate Interval Between Onset and Death
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760, ficate be g physici t the buri		FEMALE: Bb. Was decedent pregnant in t	- 12	23c. If yes, o	utcome of		y	tal death			pregnanc	ev .		Date of o		ay Year
Box 687 death certification at the attending of for use as the overline of the	2	past 12 months?			ant at time	of death		her (Sp			F 3					•
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Division of Vital Records, P.O. Box 683. To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as its additional Certification: To Be Completed by Divisional		9a. Certifier 1 Certifying P Check only 2 Medical Exa	miner:Or	n the basis o	of examina	owledge, d ition and/or	eath occur investigat	red at th	ne time, dat ny opinion,	e and pla death oc	ace, and d curred at	ue to the caus the time, date	se(s) and and place	manner e, and du	as state ue to the	id. ∋ cause(s)
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	2	Pamela E. Southall, N		ssistant i	Medical strar's S		er 11	1 Pen	n Street,	Baitin	nore, MI	21201			_	
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2. per MD g900 2/4/10 TT
State of Maryland / Department of Health and Mental Hygiene Amend #2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **2010**/ear Physician/ Month Dorothy E. Halberstadt 2009 305 Januarv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WMHS-REGIONAL MEDICAL CENTER CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Year 1917 1 □ M 2 🗓 F (Month, Day, ine 20 Months Days Hours Min. Director 92 217-03-1250 June Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 V No MD Allegany Frostburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21532 101 Candlewick Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 💢 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Francis Hornick, Sr. Elsie Josephine Sauerwald Page 1 and 2 should ment of Health and N ant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary R. Sadecki 4435 Kendi Road; Baltimore, MD 21236 / daughter 20a. Method of Disposition

1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Other (Specify) 4 Donation 5 Dulaney Valley Mem Gardens ! 2/2/10 Timonium, MD I envice Visins 21. Signature of Fune 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) JKNO Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death 9 Unknown Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed this certificate 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Depatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, Voger CARUMO 29 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Welik 12502 Willowbrook Rd. Suite 450: Cumberland. MD_21502 FEB 0 4 2010 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ANDREE HARDINGHAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Ellicott City Rehab & Nursing If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month Day 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 213-28-2996 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director DE Sussex Frankford 10e Street and Number 32502 Powell Farm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was D If Yes, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Ye 2 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's (Give kind of life. DO NO Elementary/Secondary (0-12) College (1-4or 5+) Clinic C 17. Father's Name (First, Middle, Last) Be Leon Le Bon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add Linda S. Trader / Daughter 103 Cor 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 21. Signature of Funeral Service Licensee 22. Nam 3 410 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE /Medical Due to (or as a consequence of): **Examiner** Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trans Due to (or as a consequence of) and attending physician for use as the buria DDV Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underly

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shalwn mal

FEB 0 4 2010

1. Decedent's Name (First, Middle, Last)

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Tyes

27. Manner of Death

1 Natural 2 Accident

3☐ Suicide

29a. Certifier

4 Homicide

9 Unknown

Physician

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4c. County of Death

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The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the been signed to should be deta page 2 s To the Hospital or Attending Physician: nours after death.

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filled in by the funeral director, 24 hours a

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Certification:

Medical

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Baltimore, Maryland 21215-0036 Box 68760 P.0. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02974 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year en Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Days 03 Hours Min. 09/22/09 Maryland Director 219-85-1500 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABaltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Thomas Avenue 1811 21216 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married o. 2 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black "natural", 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martell Maith <u>Antoinette</u> Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Jones(Mother) 1811 Thomas Ave., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mem. 01/30/10 Park Baltimore, MD Signature of Funeral Service Licenses Joseph H. Brown Jr. 2140 N. Fulton Ave., Fulton Ave.,Baltimore,MD 21217 Approximate Interval 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Pa. , Medical Examiner Due to (or as a consequence of): Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death ed by the a detached f g Unknown g Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed? Yes 2 No certificate 1 Yes 2 No Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 \square No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of e Hospital or Attending PI 124 hours after death. e Funeral Director: After the leted filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury Accident 2 No Investigation M 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) Wal 32. Rec State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 4:59 РΜ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Hours Min. (Month, Day, Year) 04/08/1925 431-30-9624 84 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Washington 1 X Yes 2 No DC 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20011 3700 N. Capital Street AFRH 911 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

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Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced "natural" Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Staff Sergeant 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Deaver Margaret Nutt Don 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 S. Erie Street, De Pere, WI 54115 Karen Mathys / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hanover, Maryland 2/3/2010 Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Sepice Lic-22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final evosaleroh Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a porisection neigh-Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death s been signed by the sahould be detached Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death. Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the ! only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Univarily BLVD 2231 31. Date filed (Month, Day 32. Registre 's Sign State

Registrar

FEB 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of Ma	•	partment of Health and N Certificate of Death	nentai Hygien Reg.N	2010 0297	6
	Physici	an	1. Decedent's Name (First, Middle, Last) Thomas William Jones	Jr.		2. Date of Death Month D January 27	3. Time of Death 7, 2010 11:01 a	Л
a de la companya de l	/Medio	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	4	c. County of Death	\neg
A		_	Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthd	Laurel av) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	ince Georges 9. Birthplace (State or Foreig	gn
i	Funeral Director		578-64-7400 XDM 2DF	63 _{Yrs}	Months Days Hours Min.	07–22–1946	Washington DC	
	/land low		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			10d. Inside City Limits	s
	e Mary 8a-f sh ptified	ctor	MD PG		Laurel		1X Yes 2 No	0
	3a or 2	al Dire	10e. Street and Number 6907 Redmiles Rd.		10f. Zip Code 20707	10g. C	Citizen of What Country? USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
2-00	72 hour natural	eted t	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occupation live kind of work done during most of work		Kind of Business/Industry	
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5	`life	e. DO NOT use retired) ting Plant_Worker		ernment	
nd 2	e filed al Hygi I other vent, I	Be Co	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maide	en Surname)	
ryla I	2 should be f h and Mental 7 is marked o raumatic eve	욘	Thomas William Jones Sr. 19a. Informant's Name/Relationship (Type. Print)	-	Mary ailing Address (Street and Number or Rui	Hartsfield		-
, Ma	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Jacqueline Jones/ Wife	I	Redmiles Rd. Laure			
Baltimore, Maryland 21215-0036	Pages ment o ant; If i		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		Memorial 2-2-	10 Lan	Location - City or Town, State	
Ball	permit. Departr Importa any Inj		21. Signature of Funeral Service Licensee	11	22. Name and Address of Facility Ron 10583 Middleport Ln	_		
E			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ne.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death	1
E	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ia			Onset and Death	
ĺ	Examiner		Sacral I	a consequence of): Decubitus				
	ted	Examiner	Cause, Enter Underlying Cause, Oisease or injury	a consequence of):				
oʻ	icate be executed physician and the burial-transit	Exar	that initiated events c. Diabeles	a consequence of):				_
68760,	tificate be executed g physician and as the burial-transit	ledical	d					
O. Box	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant ar 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	_	23d. Date of delivery Month Day Year	
rds, P.	w requires that to be the signed by should be detach		Part II. Other significant conditions contributing to death be Sepsis	ut not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknow	vn
al Records,	Physician: The law re this certificate has be al director, page 2 sho	Completed by				24a. Was an autopsy performe ?? 1 □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	le f
Vita	ysiclan s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatie	ent 2 ☐ ER/Outpa	Other:	h (Check only one) ome 5 ☐ Residence	6 ☐ Other (Specify)	
n of	ing Phy After thi uneral o	on: T	27. Magner of Death 1. Natural 5 □ Pending (Month, Da	ry 28b. Tim	e of 28c. Injury at Work?	28d. Describe how in		
Division of	al or Attending Physician: s after death. Il Director: After this certifica ad in by the funeral director, p	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injuding, etc.	ury - At home, farm, c. <i>(Specify)</i>	M 1 □Yes 2 □No street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C		f examination and/o	leath occurred at the time, date and place or investigation, in my opinion, death occu			
	To the within the complex comp	Ž	29b. Signature and title of certifier		29c. License number DOD 662		Date signed (Month, Day, Year)	
	101		30 Name and address of person who completed cause of d		pe, Print)	0 1	12010	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registro	arla Cianatura	300 Van Dusen	Kd. La	ore!, MD 20707	
	Registr		FEB 0 4 2010 General &	as signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 02977 For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year LOUIS 3:38 PM 2010 Ephrupa-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death N/A HOSP: ton more CITT Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min 3-278 Day Yearly MARYLAND 219-42-7182 65 Director Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 ☐ No N/A MD. BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 3103 WOODFORD PLACE APT F 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 X Divorced BLACK the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCE CLERK -9--0-GIANT FOODS t of Health and Mental Hygilitem 27 is marked othe or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HORACE JOHNSON ANNIE WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY JOHNSON (SON) 3115 GARTSIDE AVE. BALTIMORE MARYLAND 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 ☐ Burial 2/X Cre nation 3 Removal from State Department of Important: If any injury or METRO CREMATORY 2-9-2010 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Functal Service Licensee JONATHA HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sho, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final diseas o condition resultin in death) Physician/ CARDIAL ducish th Medical Due to (or as a consequence of) Examiner MTO condid it mmedint Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) CONUMART Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and each filled in by the Iumeal director, page 2 should be detached for use as the burial-transit YEAR" ANTONY DISCAR that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 | No Other: Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie 29c. License number DYKOVITZ 0061438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

South MANWER

BUKOVITZ

Date filed (Month, Day, Year)

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0410 2010 Sadie Joan Lee Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 X Days Hours (Month, Day, Director 215 56 5167 60 FFeb. N Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4126 Dudley Ave. 21213 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0036 $\bar{\mathbf{x}}$ 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Roger Cunningham, Lois Brandon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5502 MCormic Ave. Balto, Co. Md. 2120 Cheryl Phillips (niece) 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Feb.5,201 4 Donation 5 Other (Specify) Mausol Jum Gardens of Faith Baltimore,Md 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 21. So ature of Funeral Service Licensee 2 E Preston St Balto, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ VO SEPSIS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury Examiner a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 4 Pregnant 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Dunknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s performed' Yes 2 1 ☐ Yes 2 ► No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ျှ 1 🗌 Yes 2 **N**0 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of injury (Month, Day, Year) Certificate: 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending neral Director; A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29c License number 29d. Date signed (Month, Day, Year) 2010 death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

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Kim Lavale Jones										

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State of Maryland / Department of Health and Mental Hygiene	2010	02979
Cortificate of Dooth		

		l- For State Registrar	_	Certi	ficate of	Death			Reg. No	D		
Physicia Medical Examir	n/	 Decedent's Name (First, Middle,La 	_	ones				2. Date of I Month Januar		Year	3	3. Time of Death 0830 hrs
		4a. Facility Name (if not institution, g 1134 Stoddard Court	ive street and nu	mber)	41	o. City, Town, or Baltimore	Location of			c. County of D	Death	
Funeral Director		5. Social Security Number 6. S	Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day		Min.	•		Coun	
s after death with iral", or items 23,	mpleted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. Street and Number 4616 Furley F 11. Marital Status 1 Never Married 2 Married	12. Was Dec Armed For 1 Yes If Yes, Give Yea or Dates: College (1	edent Ever in U.S. orces?	13. Was If Ye 1	10f. Zip Code 21206 Decedent of His s, specify Cubar	n, Mexican, lospecify: tion (Give kie. DO NOT u	n? (Specify Yes or Puerto Rican, etc.) ind of work done	10g. Ci	White, e Specify: B Kind of Busin	Countrica America etc.	Od. Inside City Limits 1 Yes 2 No y? In Indian, Black,
21218 hould be fill and Mental H is marked tite event, 1	å	Caryle Jon	Type, Print)				et and Numb	cy Stubb per or Rural Route I	Number,			(ip Code)
Baltimore, MD 2121 pernit. Pages I and 2 should be fi Department of Health and Mental I Important: If tiem 27 is marked injury or other traumatic event,		Ashley Buise 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Denation 5 Other Specification of Funeral Service Lice	Removal fro	om/State 20b. Pla	matory or other	on (Name of ce er place)	metery,	Date FEB.8,20 ruggs Fu	20c	. Location - Ci	ty or To	
Medical	1	23a. Part I. Enter the disease, or comfailure. List only one cause on the contract of the cont	each line.	L	no not enter the	mode of dying,	Prest such as car	on St.	Bal arrest, sh	to Md nock, or heart	7	1 21 3 Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)		and meth consequence of):	adone :	intoxica	<u>ation</u>				(2)	Deau
7 4		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	consequence of):								
execut ian and ial - tra	Medical E	X UNPENDED	amended	3a,27,28a	-f .ne	rm.E ø9(02 4.1	9.10 TT				
Box 68760, e death certificate be extending physician ed for use as the burial	Physician/Me	IF FEMALE: (3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow	23c. If yes, of Live b	outcome of pregnar irth ant at time of death	ncy 2 Feta		Ectopic (23	3d. Date of de Month	livery Day	y Year
_ e = e		Part II. Other significant conditions	contributing to	death but not resu	ulting in the un	derlying cause (given in Part	1 —	_			e cause of death?
ion of Vital Records, P.O. I tending Physician: The law requires that the earth. On the this certificate has been signed by the funeral director, page 2 should be detached.	Completed by			. <u> </u>				1 v Y€	itopsy erform <u>ed</u> ?	prio dea	r to con	osy findings available npletion of cause of
Vital F hysician: this certifi	ă۱	25. Was case referred to medical examiner?	Hospital: 1	npatient 2 El	R/Outpatient		Othor:	Nursing Home 5	Resid	lence 6 🗸	Other: S	scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Certification: To	1 V Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28e Place		8b. Time of Inj	hrs 1	ry at Work? Yes 2 X I	No unk	be how in	jury occurred		Route Number, City
	Certif	3 Suicide 6 X Could no determin 4 Homicide 29a. Certifier 4 Could no determin	ed (Specify)	oth	er			Balt	n, State) IMOT	1134 St	todo	lard Ct
To the Hos within 24 h To the Fun completely	edica	(Check only one) 2 Medical Examine	cian: To the bes er:On the basis of and manner s	it of my knowledge, of examination and tated.	, death occurre /or investigation	n, in my opinion	n, death occu	e, and due to the curred at the time, d	ause(s) a ate and pi	nd manner as lace, and due	stated to the o	cause(s)
	Ž	29b. Signature and fitte of certifier	and the second s	IN P		29c. Licens O.C.				Date signed nuary 28, 2		ı, Day, Year)
		30. Name and address of person who Russell Alexander MD.				Penn Street,	Baltimor	e, MD 21201				
Sta Regist		31. Date filed (Month, Day, Year)	2010 32. Re	egistrar's Signature	1 1							
DHMH 17 Rev 1/20	_		4010 /	in the second	ORIGINAL	ale		Ú	UNE			OCME

DHMH 17 Rev 1/2001 OCME 2006

10-00864 Julie Ann Kleinhans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certif	icate of	Death			F	Reg. No.			
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd	^{ile,Last)} Ann Klei	nhan	ıs					Date of De Month January	Day	Year		3. Time of Death 1124 hrs
		4a. Facility Name (if not institution	on, give street and				4b. City, Town,	or Location		oundary .	4c. (County o		-h.
		955 Fairmount Avenu		1-			Towson	1.57						
Funeral Director		5. Social Security Number 255–45–3729	6. Sex 1 M 2√CXF		In yrs. last	birthday) 43 Yrs	Months Da	ays Hour		Octol 1960	oer 8 S	D/YYYY) •	Foreign	nplace (State or WISCONSIN Intry)
706	t	Usual Residence of Decedent												
id frow any		10a. State 10b. County Maryland Balt.	imore	10	oc. City, To	wn or Locati TC	on WSON							10d. Inside City Limits 1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number 955 Fairmoun	t Avenue				10f. Zip Code	204			10g Citize Uni			
ith the		11, Marital Status	12. Was D	acadant Ev	er in II S	13 Wa	s Decedent of I	Hispanic Or	igin? (Spec	ify Ves or N		Ame		an Indian, Black,
ath w	Funeral		larried Armed	Forces?			es, specify Cub				o- '-	White,		arr indian, black,
	by Fu	3 Widowed 4 Div	vorced If Yes, Give Y		No	1	Yes XX	No specify	r.		S	pecify:	Wh:	ite
lours a		15. Decedent's Education (Spe	ecify only highest gr	rade comple	eted) 16		t's Usual Occup ost of working li				16b. Kin	nd of Bus	iness/In	dustry
136 hin 72 hours afte than "natural", edical Examine	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)	4		cher			-,		duca	tion	2
5-00% lled with Hygiene d other ti	ē	17. Father's Name (First, Middle			4	160	icher	18.Mothe	r's Name (F	irst, Middle,			CIOI	
21215-0036 and be filed within 7 Mental Hygienc. marked other than cevent, the Medical	Be	Lyle Kleinh								Grybo				
21 nould id Me is ma	P	19a. Informant's Name/Relations Mr. Lyle Klein		her			Address (Str Upton S							Zip Code) • 20016
re, MC s 1 and 2 s of Health an If item 27		20a. Method of Disposition					ition (Name of o	cemetery,		Date	20c. Lo	cation -	City or T	own, State
Baltimore, MC permit. Pages 1 and 2 sl Department of Health ar Important: If iten 27 injury or other trauma		Burial 2 Cremation 4 Donation 5 Other S		from State	Evar	natory or oth NS Fun	ieral Ch	napel	Febr		For	est	Hil	l, Maryland
altir mit. F partme porta ury ou		21. So t of Funeral Service				22 N	ame and Addre	ss of Facili			_			on Ctr.,P.A
W F S E E		114.10.50				-10	2325 YC	ork Ro	ea Ti	monium	n, Mar	утаn	a z	1093
Physician /Medical		23a. art I. Enter the disease of failure. List only one cause	on each line.		e death. Do	not enter th	ne mode of dyin	ig, such as	cardiac or re	espiratory ar	rest, shock	k, or hea	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as		uence of):								-	Death
	<u></u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as											
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated												
3760, ficate be executed g physician and s the burial - transit		events resulting in death) Last	d	a consequ	ierice or).								- 0	11
be exectician (n/Medical	X UNPENDED	AMENDED	23a,	27,28	a-f,p	erm,E g	900 2	/18/1	O TT				
8760, ifficate being physic as the bur	¥.	IF FEMALE: 23b. Was decedent pregnant in t		s, outcome	of pregnan	су		_				Date of c		Vant
Box 68 death certif	cian	past 12 months?	LIVE		ne of death		tal death 3 ner (Specify)	Ectop	c pregnanc	у		lonth	Da	ay Year
Box 68 le death certi the attendin	Physicia	1 Yes 2 No 9 ✔ Un	known 9 Unk	nown			55 55							
	by P	Part II. Other significant condit	tions contributing	to death b	ut not resul	ting in the u	nderlying cause	e given in P	art I.			_	_	ne cause of death?
ls, F quires en sign										24a. Was				opsy findings available
tal Records cian: The law requi certificate has been	Completed									auto		pr		mpletion of cause of
Rec The l	틼									1 Yes	2 No		✓ Yes	2 No
tal ician: certif	ě B	25. Was case referred to medica examiner?	Hospital:	l	2	10		Other	(Check onl		ln. n	0 [4	l ou	
f Vi	위	1 ✓ Yes 2 No 27. Manner of Death		Inpatient te of Injury		Outpatient b. Time of Ir		jury at Worl		Home 5				bject found
Division of Vital Records, P.O tal or Attending Physician: The law requires that tress after death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detended in by the funeral director, page 2 should be detended.	흷	1 Natural 5 Pend	ding (Mor	nth, Day,Year)		1	Yes 2X	ING W		lasti	c ba	g o	ver her hea
r Atte r Atte fer dez irecto	<u>[ã</u>		oligation	. / 30 / 1 ace of Injury		1 11:2 , farm, stree	t, factory, office	building, e	tc. 28	f. Location	Street and	Number	or Rura	al Route Number, City
Div ospital or hours aft ineral Di	Certification:	4 Homicide dete	ermined (Specif	y)	fo	und:	resider	ice	Т	or Town, OWSON	state) 95 MD	5 Fa	irmo	ount Ave
	Medical (Chook only	hysician: To the basi	s of examin	-									
To To con	ξ	29b. Signature and title of certific	and manner er	stated.			29c. Lice	nse number			29d. Da	te signe	d (Mont	th, Day, Year)
		ing w.	Lun				0.0	C.M.E.			Janua	ary 31,	2010	
N V		•	ant Medical Ex				t, Baltimore	, MD 212	201					
Sta Registi	ite rar	31. Date filed (Month, Day, Year),	4 2010 32.1	Registrar's	Signature	ba	ike							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b, perFH, G900, 2/4/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** C Q Unde OSPIC 5. Social Security Number If Under I Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Min. 1 M 2 F Months Days Hours 9 -198 Yrs. 213-28 Director January 10,1918 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director PIKESY Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21908 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specity Specity: 3 Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene, th ursing 19 Hssistant Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, I once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be tho ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave. nde Balta MD 3 1 doughta 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specity) son Forest 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 270 Frenhilton Baltimore, MD2122 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line. Approximate Inter al Between On et and Death 002 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specity) signed by the a d be detached f 1 □ Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 🗌 Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 Residence 28c. Injury at Work? 27. Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 D Aatural 1 🗌 Yes 2 🗌 No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GLADYS JAN **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Prince Georges' If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In vrs. last birthday) 1□ M 2□ F Hours 81 Director 577-40-5435 04/15/1928 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show Director 1 TXYes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 1919 Lincoln Road, 20002 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the IM. Elementary/Secondary (0-12) College (1-4or 5+) 2 years Customer Service Rep. Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lewis Alice (Unknown) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean L. Resse - Daughter 1919 Lincoln Road; NE Washington, DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 02/05/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Sign of Funeral Service License 4594 Beech Road; Temple Hills, MD 20748 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bause on each line.

SARCOMA OF PSOAS 23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.
neral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely DO067634

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 1396 PICCARD DRIVE ROCKVILLE, MD 20850 SANDRA L. SWANN 2. Registrar's Si

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19a, 22 per 1h g900 2-4-10 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:00 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 746 Buckeye Court Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 28, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 F Months Days 285-40-3470 90 March Ohio Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, Ire Neglical Eva ninger must be retified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director 1 ☐ Yes 2 ☐ No Anne Arundel Millersville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 746 Buckeye Court 21108 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes XXNo Specify: 2 Specify. 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Cleveland Harris Elizabeth Rebecca Nease ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Millersville

5 08 French Point Ct. Millersivlle, MD 2110 permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr daughter Kathleen Marie Elmore 508 French Point Ct. M. MD 21108 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 2/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Highland, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, shock, or heart failure. Li Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequ a e of): Examiner Sequentially list conditions Physician/Medical Examiner Lue to (or as a consequence of) day, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, the JF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 No Month Year P.0. 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 □Yes 2 No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XX 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 2 ☐ Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day; Year)

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DHMH 17 Rev 1/200

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Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MU

32.

Joseph William	Lutz		e or Print in Bl e of Maryland						_	0 00001
		1- For State Registrar			tificate o				201 Reg. No.	0 02981
Physicia Medical Exami		Decedent's Name (First, Middle, L JOSEPH WII		JUTZ,	JR.			2. Date of De Month January	eath Day Year 28, 2010	3. Time of Death 0930 hrs
		4a. Facility Name (if not institution 1042 Kreitter Valley Ros				4b. City, Town Forest H	, or Location of D		4c. County of D Harford	eath
Funeral Director		215 56 0252	Sex 7. Age XM 2 F	e (In yrs. las	st birthday)		Year If Under 2 Days Hours	Min		Birthplace (State or reign Country) MD
ow any		Usual Residence of Decedent 10a. State 10b. County MD HA	RFORD	10c. City, 7	Town or Locat		REST HI	ГТ.Т.		10d. Inside City Limits 1 Yes 2 Y No
re Maryland or 28a-f sh	Director	10e. Street and Number Kreit1 1642 KREITTER	er	ROAD	<u> </u>	10f. Zip Coo			10g. Citizen of What (
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygene. If Iftem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral I	11. Marital Status 1 Never Married 2 Married	Ever in U.S				? (Specify Yes or Nuerto Rican, etc.)	Io- 14. Race - Ar White, et	nerican Indian, Black, c.	
hours after natural", o	ρ	15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade com	pleted)	16a. Deceder		No specify: upation (Give kin life. DO NOT us		Specify:	WHITE ss/Industry
-0036 d within 72 giene. ther than "	Completed	Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, La	College (1-4 or 5	o+)	S	ELF E	MPLOYET		CONST:	RUCTION
1215 Id be file fental Hi narked o	Be	JOSEPH WILL 19a. Informant's Name/Relationship	IAM LUT	z, s		Addross (C	DOF		ROSE	(WAGNER)
MD 2 id 2 shou lith and M m 27 is n	우	KAREN D. LUTZ			419	HOPKI	NS LAND	ING DRI	VE ESS	EX, MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY 21. Signature of Funeral Service Licensee 20c. Location - City or crematory or other place) METRO CREMATORY 22. Name and Address of Facility CVACH / ROSEDALE FUIL 1211 CHESACO AVE ROSEDALE. MI								
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on		the death. [ESACO A		SEDALE, I	Approximate Interval Between Onset and
/Medical Examiner		•	a. Carbon Monoxid							Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	100						
e executed sian and sial - transit	ical	UNPENDED UNPENDED	W AMENDED -		_		4/10 TT	ጥጥ		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal - transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c, If yes, outcom 1 Live birth 4 Pregnant at	e of pregna	ancy 2 Fe	tal death	2/19/10 3 Ectopic pr		23d. Date of deli Month	very Day Year
P.O. res that the signed by the	by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	inderlying caus	se given in Part I		tobacco use contribute es 2 No 3 F	to the cause of death?
Records The law requi	Completed							1 Yes		autopsy findings available to completion of cause of ? Yes 2 No
Vital Rec hysician: The la this certificate by al director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗌 E	R/Outpatient		other N	ursing Home 5	Residence 6 🗸 0	her: Scene
ion of trending Ph leath. tor: After tree the funeral	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred									exhaust fumes
Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:	3 Suicide 6 Could n 4 Homicide Certifier 1 Certifying Phys	ned (Specify) Gar	age	_			1642 Kreitter	Valley Road, Fores	
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only	ician: To the best of my er:On the basis of exam and manner stated							
	ž	29b. Signature and title of certifier	well, did				ense number		29d. Date signed (
251		30. Name and address of person wh Melissa Brassell, MD	o completed cause of de Assistant Medical	,	,	enn Street	, Baltimore, I	MD 21201		
St Regist	ate	31 Date filed (Month, Day, Year) FEB 0 4 2010	32. Registrar	's Signature		,				

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0.26PM Physician James Lunceford 2010 01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MANOR CARE NURSING FACILITY ROSSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 - 7 - 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1**X** M 2 □ F 254-28-2915 86 GEORGIA Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extenir ar must be notified at BALTIMORE ROSEDALE 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiene.

ant; If item 27 is marked other than "natural", or items 23a or 8310 PHILADLPHIA ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 1943-55 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) LUNCEFORD SERVICE Elementary/Secondary (0-12) College (1-4or 5+) STATION 12 SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT GARLAND LUNCEFORD JOSEPHINE (HILLIARD) ပ 19a. Informant's Name/Relationship (Type. Print)
NORMALEE H. LUNCEFORD/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 3 1 0 PHILADELPHIA RD ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important; If ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-2-2010 ZION CHURCH CEM. BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE 21237 ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8x098 3260 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and retely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Ahrol Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1∐Yes 2∐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 □Yes 1 TYes 2 □ No 2 1 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

24 hours a within 2

SHOAIR State Registrar

(Check only

29b. Signature and title of certifier

1

821 HASHMIMD N. EUTAW ST 32. Registrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

completely

MD

29c. License number

3146

Suite 308

29d. Date signed (Month, Day, Year)

30/10

Baltimore MP 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	partment of Health and Nertificate of Death		
Physi	ioion	Decedent's Name (First, Middle, Last)		Reg. I	3. Time of Death
/Me	dical	Mabel LaPole	1 0 T	January	29, 2010 4:30 A. M
Exam	niner	4a. Facility Name (If not institution, give street and number) Marley Health & Rehab.	4b. City, Town, or Location of Death Glen Burnie		tc. County of Death Anne Arundel
Funera	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Directo		218 18 6393 TILIM 2LAF 97 Yrs. Usual Residence of Decedent		08/08/19	12 Maryland
ryland how		10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits
he Ma 28a-f s	Director	, , , , , , , , , , , , , , , , , , , ,	Burnie		1 ☐ Yes 2 📉 No
with t		10e. Street and Number 7575 E. Howard Road	10f. Zip Code 21061	10g. (Citizen of What Country?
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
s after	by Fu		1 ☐ Yes 2 🖾 No Specify:	nican, etc.)	Black, White, etc.
5-0036 72 hours aff natural", or	ted t	3 LX Widowed 4 Li Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	Specify: White Kind of Business/Industry
ithin 7 ne. nan "n	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ing	
Hygier Ther ther the	S	11th HC	omemaker	e (First, Middle, Maide	Own Home
land lid be filk fental H rked oth iic event	To Be	Table 11		t availabl	
and N			ling Address (Street and Number or Run	al Route Number, City	y or Town, State, Zip Code)
e, N 1 and Health em 27 ther tr			Seagrove Road		ie, Maryland 21060 Location - City or Town, State
ages ent of nt: If its		1 Labouriar 2 Li Cremation 3 Li Removal nom State	ematory or other place)		•
DallIIIIOre, IMaryliand ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Executer must be relitied at	once.	21. Signature of Fineral Service Licensee	22. Name and Address of Facility Go	nce Funera	en Burnie, Maryland 1 Service. P.A.
9 9 9 E	8	flens Oldridge	4001 Ritchie Highw	ay Baltin	nore, Maryland 21225
	0	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physiciai /Medica	_	disease or condition resulting in death) Due to (or as a consequence of):	rac stryin	wa	
Examine			t		
ted sit	Examiner	Sequentially list conditions, if any leading to limit the cause. Enter Underlying Cause (Disease or injury			
execu in and ial-trar	Exan	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d			
A OC Sertifications of ding places to see as t	Med	IF FEMALE:			
death certific	hysician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
at the de lby the	hysi	9 Unknown			
res tha signed be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
w requir been s should	eted	V 41/42 66 / (1/10-		1 Tes	
The law	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Iclan: The certificate ector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☐ N n (Check only one)	No 1 □Yes 2 □No
_ × × × × × × × × × × × × × × × × × × ×	ြင	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time			6 ☐ Other (Specify)
nding Ith. : After e funer	tion	Matural 5 Pending Month, Day, Year Injury 2 Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
or Attending Physician: or Attending Physician: fifer death. Director: After this certifica in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
Hospital o 24 hours aff Funeral Di ttely filled ir					
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, dea and manuer stated.	un occurred at the time, date and place, nvestigation, in my opinion, death occuri	and due to the cause ed at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
		1 1 1	D57028		in. 29,2010
\		30. Name and address of person who completed cause of death (Item 23a) (Type	dall Divest	+ 231 Ar	mizalis mo riun
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 4 2010 August A. Aards	coping no co	2001111	"MYCHO IIIDS 110
Regis	trar	FEB 04 2010 Senus S. Jak			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Feb Rose Μ. Lettieri 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth 1 □ M 2 🕱 F Months Days Hours Min. May 31. 1910 Director 212-10-5620 99 Yrs. Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 No Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Court Unit 112 21286 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: 3XXWidowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Onorato Marie Rose Tuminello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Onorato/Nephew 2 Ruxton Green Ct. Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 XOther (Specify) Entomb Parkwood Cemetery 2/6/10 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licen 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. MID Fracture disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen: 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy perform death? 24 hours after death.

Funeral Director: After this certificate is Funeral Director Dan ☐ Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 \square Nursing Home 5 \square Residence 6 \bigvee Other (Specify) Wife \bigvee Certificate: To 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury , (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident January 10, 2010 Fall while ambulating with walker 2 🔀 No UNK Investigation

Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined home Cassisted Living Facility 800 SOUTHERLY READ, TOWSON MO Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

6701

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32. Regiş

HARLES

31. Date filed (Month, Day, Year)

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NULMET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 DANIEL THOMAS MURPHY 9:10P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 227B Rodgers Forge Road Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X**XM 2 □ F Months Days Hours 122-14-2617 Maynth 30 y, 1923 86 Director New York Usual Residence of Decedent show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2**)** No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 227B Rodgers Forge Road 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1XXXYes 2 □ No WWII Black, White, etc. 1 Never Married 2XX Married Maryland 21215-0036 1 Yes 2XX No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify: Completed White traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Accountant <u>Insurance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Timonthy Murphy Johanna Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra DTR Lupe Gwiaxdowski 816 Hatterleigh Road Baltimore, Maryland 21212 Baltimore, 20a. Method of Disposition

XX
Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Mem Gardens Feb 9,2010 Timonium Maryland Donation 5 - Other (Specify) 22. Name and Address of Farmy Chell-Wiedefeld Funeral Home Inc ature of Funeral Se 6500 York Road Baltmore, Maryland 21212 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one on ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury s been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🛣 No မှု 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c, License number 22/04/10

State Registrar 31. Date filed (Month, Day, Year,

13

DHMH 17 Rev 7/2009

2205 York Rd. 51,101

TIMONIUM, Md. 21083

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryla		artment of l rtificate of			giene Reg. No. 2011	0 02989		
	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last</i> Dolores Ma	xine Moennicl	n			2. Date of Dea Month January	Day Yea	- 1 O- A M		
Examiner		ner	4a. Facility Name (If not institution, give ST - AGNES HDSPIT	AL		BALTIM	4b. City, Town, or Location of Death BALT IMOYSE			4c. County of Death N/A		
	Funeral Director		213-03-1010	7. Age (<i>In yr</i> s	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt Sep • 21	y, Year 917 Ti	irthplace (State or Foreign Country) idiana		
	/aryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Balti		City, Town or Lo	cation Halethor	pe			10d. Inside City Limits 1 ☐ Yes 2 No		
	with the Na or 28a-	Director	10e. Street and Number 1017 Francis Av	10f. Zip Code	21227		10g. Citizen of What Country? United States					
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Ezon instruction and once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1		Nas Decedent of l fYes, specify Cub I □Yes 2 No	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036		Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	(cation le completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done OO NOT use retire	during most of work ed)	ing	16b. Kind of Busines	·		
/land		To Be C	17. Father's Name (First, Middle, Last) George Robert Ed	wards			18. Mother's Name	,	Maiden Surname)	·		
, Mar			19a. Informant's Name/Relationship (7) Anita Moennich		19b. Mailin 414	g Address <i>(Street</i> South Da	tand Number or Run allas St.,	al Route Numbe Baltin	er, City or Town, State nore, MD 2	, Zip Code) L 231		
Baltimore, Maryland			20a. Method of Disposition 1 XBurial 2 Cremation 3 F Donation 5 Other (Specify)	Removal from State		natory`or other pla	ery 2-5-2	Date 2010	20c. Location - City of Baltimore	<i>'</i>		
Balt	Depart Import any inj		1. Si non A Punta Some Tolons	RODA	14				neral Home Arbutus, N	•		
	hysician /Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. SEPSIS a.		er the mode of dyi	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death 2 AANS		
	xaminer	J.		Due to (or as a conse	ned l	nlcer			weeks			
68760,		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C								
O. Box	by the attending phy: tached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	elivery Day Year		
ords, P.	s been signed b	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the un	derlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown		
<u>~</u>	ate h	Completed						24a. Was a autop perfor 1 □ Yes	sy prior to med? death?	autopsy findings available completion of cause of s 2 2 No		
r VII	is certification	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 🗆 DOA Oth	26. Place of Death		ne) ence 6 □ Other (Sp	nocify)		
DIVISION OF	within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor			ow injury occurred	ecity)		
DIVIS	s after dea Il Director ed in by th	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town,							reet and Number or Rural Route Number, n, State)		
Hoen.	n 24 houn	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
Ē	To t	Σ	29b. Signature and title of certifier Maurin Carmela Provales , MD 29c. License number 29d. Date signed (Mon D66007 January 3									
	21		30. Name and address of person who co	SAVES 900	Caton Au	ic Batti	more, Mo	21229	,			
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 4 201	32. Registrar's Sign	ature							
DHMI	H 17 Rev 1/20	001		- Johnson	ORIG	INAL						

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DOLORES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec. 13 9. Birthplace (State or Foreign Country)
New York 1 □ M 2XX 111-44-7249 56 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Randallstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3534 Carriage Hill Circle #202 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Specify; Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Customer Service Supvr. U.S. Airways 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dunleigh F. Briggs Florence M. Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Martin/ Daughter 4101 Prior Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Cremation, LLC 2/4/10 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris 4210 Belair Road Baltimore, 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23h Was decedent pregnant 22d Date of deliver

Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760,

n/Medical 24 hours

Physician /Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, II. Medical Evaning rout be notified at

Department of Important: If it any injury or c once.

Physician /Medical

Baltimore, Maryland 21215-0036

hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown	Month Day Year						
d by P	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably						
Completed			24a. Was an autopsy performed? 1 □ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
유	1 Yes 2 No	1 ☐ Inpatient 2 ☐ EH/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Spelity)							
ation:	27. Manner of Dedth 1	(wonth, Day, Year) Injury Work? M 1 □ Yes 2 □ No	8d. Describe how injury occurred						
Certific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)						
dical	29a. Certifier 1 Certifying Pt (Check only one)	J ysiclan: To the best of my knowledge, death occurred at the time, date and place, an niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. Ed at the time, date and place, and due to the cause(s)						
0									

31. Date filed (Month, Day, State Registrar

BOB MO 283 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

FEB 0 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>Shuford Mayes,Jr</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Prince George Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. 1951NorthCarolina Director 242-82-5766 18 Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director -28a-f 1 Yes 2 ☐ No Maryland Prince George Glenarden 10e. Street and Number 10f, Zip Code "natural", or items 23a or 10g. Citizen of What Country? by Funeral 7938 Echols Avenue 20706 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E one. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) <u>Computer Engineer</u> Insurance CO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Beatrice Poole Shuford L. Mayes, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Selma Mebane Mayes</u> 7938Echols Avenue, Glenarden, Maryland 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Macedonia Baptist 2-6-10 Taylorsville, N.C. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. A Road, Baltimore, Maryland21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ HEMATEMESIC Medical Examiner ARCINOMA THE LUNG MONTHS Service tieth list a militions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death Yes 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d UBSTRUCTIVE 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform after death. Director: After this certificate Yes 2 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 🗌 Yes 1 Inpatient 2 R/Outpatient 3 IDOA . Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 15280282 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add ANE STE 135 LALGOMD 080268 31. Date filed (Month, Day, Year) State FEB 0 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 635AM Mobert /Medical January 31 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Baltimore Seasons Hospice Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days **X**☐M 2☐F Director 061-18-3173 87 March18,1922New York Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examinar nast be notified at 10d. Inside City Limits Director Baltimore 1 ☐ Yes 🏋 ☐ No Windsor Mills Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 'natural", or items 23a 2900 Ridge Road 21244 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Y∏Yes 2 □ No if Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 □XNo Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. College (1-4or 5+) Proof Reader Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Samuel John McWhirter Hazel Irene French 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900Ridge Road, Baltimore, Maryland2124 Kenneth McWhirter/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremationServices Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** Meamonia /Medical r as a consequence of): Examiner Parkinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 2 □ No 5 Other (specify) ed by the a 1 ☐ Yes 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ difficle whitis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 🗷 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice examiner? 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:* On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) thy Seay Smith Avenue Suite 203 Baltimore, Mdzizog 2835 voro) an 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Bener S. Janes Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Paul K. Mitchell Sr. 201 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ose Balfi _dale f Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Sept. 30, 1928 5. Social Security Number Age (In vis. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 **X**M 2 ☐ F NC 81 228-24-7888 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov MD Baltimore Essex 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA "natural", or items 23a 602 Highvilla Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 Widowed 4 □ Divorced Year or Dates Completed other traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

Fork Lift Operator d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) General Motors 9+h 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva M. Beckham Charlie S. Mitchell P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Deborah Heller /daughter 602 Highvilla Road Balto. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 2/5/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Value Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 Yes 2 □ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 VINO Hospital: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760. P.O. I of Vital Records. Division

Baltimore, Maryland 21215-0036

by the a signed by the has e 2 within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page the Hospital or Attending Physician:

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

and manner stated

29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 26 2010 2010 8:20 р м Betty Jean Muntean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Tate Hospice Linthicum 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours July 24, Year 925 Ohiotry) 1 🗆 M 2 🛛 F 84 310-12-6706 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State death with the Maryland "natural", or items 23a or 28a-f sho Director Gambrills MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21054 2489 Fall Breeze Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ğ permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or any injury or other traumatic event; the Medical Examin once. 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Factory Picker Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearlie Ethel McGath Arthur Munyon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2489 Fall Breeze Court, Gambrills, MD 21054 Edward C. Muntean, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State w.Arundel Crematory 01-29-2010 Odenton, Maryland ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service License Donaldson Funeral Home & Crematory, P.A. 11411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5 N disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 9n5 201 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed: 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 24 hours within 2 To the I

Baltimore, Maryland 21215-0036

State Registrar (Check

only one) 29b. Signature and title of

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

crain

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

63+26

01/28/2010

1 m cru mon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ruth A. miller 1:25 PM February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Genesis Multimedical Center Towson, Maryland 21204 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 27, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours 215-30-6084 Director 74 1935 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Action! Examine in ust by motified at Funeral Director 1 ☐ Yes 2 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 259 Inspiration Road 21901 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alex Krupinsky Annie Elwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traum Karen Burkhardt Daughter 259 Inspiration Road, North East, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Gardens of Faith 8, 2010 Rosedale, Maryland 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. nthin 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Pa t1. Enter the disea £, ir complications that caused the shack, or heart failure. List only one cause on each line.

Immediate Cause (Final disease record): Approximate Interval Between Onset and Death **Physician** Due to (or as a c ns juence of) disease or condition resulting in death) months to year /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Renal Insufficience attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia for years 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Winary Tract Infections for months 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 **Z** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 124 hours after death.

Re Funeral Director: A pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Nuise Practitioner 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michelle E. Kalendek CRUP

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle E. Kalendek,

31. Date filed (Month, Day, Year)

CRNP

32. Registrar's Signature

R097104

7700 York Road, Towson, Maryland

2/3/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert B. Madden, Sr. Physician/ Tan Month 30 201 gar 5:46 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign County) 8. Date of Birth Funeral March 24 1940 212-38-2349 1 X M 2 □ F Days Hours Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Parkville Baltimore MD 10e. Street and Number 10f. Zip Code 21234 ō items 23a or ner must be n 10g. Citizen of What Country? USA Funeral 1803 Coburg Ct. Apt. A-2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ō ģ 1 Never Married 2 Married ☐ Yes 2x☐ No Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: "natural", Specify. Completed 3X Widowed 4 ☐ Divorced Year or Dates dical 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aerospace Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Earl Madden Pearl Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2545 Windsor Rd., Parkville, MD 21234 Lisa Conic/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/10 Stevenson AME Church Cem. Sparks, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility, semmon Funeral Home IO W. Padonia Rd., Signature of Funeral Sen of Dulaney Walleys Michael J. Flag 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. Due to (or as a consequence of) Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or imjur) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day ed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be def by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

telleco

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

29c. License number

29d. Date signed (Month. Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARTAK Physician/ Month D415 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Num 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. Ju Month, Day, 90 Director 217-09-3820 ໃ919 Mississippi Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No **Baltimore** Lutherville Md. 10e. Street and Numbe 23a or 3 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 300 Seminary Ave. 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 'natural", or þ If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: Specify: White 3 X Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Movement Director Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked ည Estelle Suit Martak Adam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5908 Point Pleasant Rd. Baltimore, Md. 21206 Department of Health Important: If item 27 any injury or other tr Mr. David Martak/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 Cremation 3 Removal from State Gardens Of Faith 2-10-10 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

WETASTATE PROSTATE CAUSE. Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examir Due to (or as a consequence of): physician Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy that the death Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No ☐ Yes 2 3 Hospital or Attending Physician: 25. Was case referred to medical B B 26. Place of Death (Check only one) 1 Yes 2 No Other: ᅆ 1 Inpatient 2 I ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be filled in by the 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowle curred at the time, date and place, and due to the cause(s) and manner as stated and ti

completed To the F

21215-0036

Baltimore, Maryland

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

DHMH 17 Rev 7/2009

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CMITIES St., Ste. 4105 Triuson

29d. Date situned (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Maniskrowski 2/2/2010 10:43A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth Nursing Home Baltimore n/a 8. Date of Birth (Month, Day, Year) 2/13/1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 W Months Days Hours Min. **Director** 89 217-14-2766 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lipiry or other traumatic event, the Medical Exercities consists and 2008. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 943 Elmridge Avenue Funeral 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Š Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Sales Clerk Retail Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Manistroski Ida Blachowicz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Bell / Niece 4747 Chester Road, N. Myrtle Beach, SC 29582 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/5/2010 Sykesville, Maryland Lakeview Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sign tur of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pheumonic /Medical Due to for as a consequence of: Examiner dementic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): burial-tran resulting in death) Last Due to (or as a consequence of) physician s the burial attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ HIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed DM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Baltimore, Maryland 21215-0036

29d. Date signed (Month, Day, Year) CZUO 212110 R111615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320 Benson Goldsborough R gistrar's Signature

State Registrar (Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
State of Maryland / Department of Health and Mental Hygiene	2010	02999
Cortificate of Death	C 0 1 0	ひとフノノ

			1- For State Registrar			,,	Certific	cate of I	Death			Re	g. No.		7 0733
	Physici	an/	Decedent's Nam	ne (First, Middle	e,Last)						Me	ate of Death	n Day Yea	ar	3. Time of Death
ME	dical Exami	ner	Harold 4a. Facility Name (if not institution		lson			rham			nuary 25	4c. County		1205 hrs
Т					Avenue Apt.			4.	Baltimore	or Location o	Death		N/A	Ji Deatti	
	Funeral		5. Social Security N	Number	6. Sex	7. Age ((In yrs. last b	rthday)	If Under 1 Ye		er 24Hrs. 8. [ate of Birt			hplace (State or
	Director		218-86-	5387	1 XM 2	F	34	Yrs.	Months Da	ys Hours	Min.	1/14	/1975	Foreig Cou	n ^{untry)} MD
0	any		Usual Residence o	f Decedent 10b. County		[1:	Oc. City, Tow	n or Location	1						10d. Inside City Limits
2		L	MD	N/A					Baltim	oro					1 X Yes 2 No
6	Maryland 28a-f show datonce.	Director	10e. Street and Nu						10f. Zip Code	IOLE		10	g. Citizen of Wi	nat Cour	ntry?
/	the N 3a or 2		3800 We	est Be	lvedre	Ave	Apt.	509	21	215			U.S.A	•	
	2) To hours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once	neral	11. Marital Status 1 X Never Marrie		12. Was	Decedent Ev d Forces?		13. Was	Decedent of H , specify Cuba					- Americ e, etc.	can Indian, Black,
	ter dea	Fur	3 Widowed		1 Yes, Give		No No		′es 2	o specify:			Specify:	Bla	ack
	ours af atural	d by	15. Decedent's Ed		or Dates:		leted) 16a	. Decedent's	Usual Occup	ation (Give k		one	16b. Kind of Bu		
	11215-0036 Id be filed within 72 houdental Hygiene narked other than "natevent, the Medical Exa	Completed	Elementary/Seco	ondary (0-12)	Colleg	e (1-4 or 5+)	during mos	t of working lif	e. DO NO Fi	use retired)				
	21215-0036 mid be filed within 7 Mental Hygiene marked other than c event, the Medica	omp	17, Father's Name	(First Middle	1yea	<u>r</u>		Ch	ef	18 Mother's	s Namo (First		Philli aiden Surname		
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	212 tould b d Men s marl	10	19a. Informant's Na							et and Num	ber or Rural F	Route Numl	ber, City or Tow	n, State,	Zip Code)
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		Harold 20a. Method of Dis		m 1st(Fathe	er) [303	Marav. on (Name of c	ia Rd	l_apt.	K,Ba	ltimor	e,M	ID 21206 Town, State
	Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 Burial 2		3 Remov	al from State	Jose	Book of B	rown	F/H					
	it. Pag rtment rtant: y or o		4 Donation 5 21 Signature of Fu	Other Spanice		-	And	Crem	atory				Balti		
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23	/MI Examiner		Immediate Cause (Final disease	a			Pre	sumed (compli	cation	s of	diabet	2 S	Death
			or condition resulting		Due to (or a	as a consequ	uence of):								
		ner	Sequentially list con if any, leading to im- cause. Enter Under	nmediate	Due to (or a	as a consequ	uence of):								
	-	Examiner	(Disease or injury to events resulting in	hat initiated	Due to (or a	as a consequ	uence of):								
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			IF FEMALE: 23b. Was decedent past 12 months			es, outcome ve birth	of pregnancy		death 3	Ectopic	pregnancy		23d. Date of Month	,	ay Year
	Box 687 e death certific the attending p	sician	1 Yes 2 N			egnant at tin iknown	ne of death	5 Othe	r (Specify)						
	O. B. tr the de by the ached f	Phy	Part II. Other signi	ficant condition			ut not resulti	ng in the und	derlying cause	given in Par	rt I. 2	3e. Did tob	pacco use contri	bute to t	he cause of death?
	tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	d by			<u>.</u>							1 Yes	2 No 3	Prob	ably 4 🗸 Unknown
	ords v requi s been should	Completed									2	4a. Was autops			opsy findings available ompletion of cause of
	Che lav	mo.									1	perform ✓ Yes 2		eath?	s 2 No
	tal F	Bec	25. Was case reference examiner?	red to medical	Hospital: 1					Othor	Check only or				
	Physical directions	유	1 Yes 27. Manner of Deat	2 No	28a. D	Inpatient ate of Injury		Outpatient :		ury at Work?	Nursing Hom		Residence 6		Scene
	on of anding Plath.	ţi	1 X Natural	5 Pendi	ng (M	onth, Day,Year)		·	Yes 2		3000112011	on injury cooding		
	Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	2 Accident 3 Suicide		tigation 28e. P	lace of Injur	y - At home,	farm, street,	factory, office	building, etc		ocation (St		er or Rur	al Route Number, City
	Spital hours a neral I	Ser	4 Homicide	deterr	1,000				-		- 1				
W	Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Medical	(Check only		ysician: To the niner:On the bas	sis of examir	-								
1 A Br	To Witi	Me	29b Signature and	title of certifie	and manne	er stated	38X		29c. Licen	se number			29d Date signe	d (Mon	th, Day, Year)
			Jula	Valla	er les	be	1		O.C	.M.E.		ĺ	January 26	, 2010	
			30. Name and addre		•			144.5	nn C+ + 1	Delti	MD 0400	I			
		ate	Victor Weed		Assistant I	1	Signature -	111 Pe	nn Street, I	baitimore	, IVID 2120	71			
	Regist	rar	31. Date filed (Mont	EB 04	2010	Eners	1	bar	6						
D	HMH 17 Rev 1/2	001		0	OME		Ö	RIGINAL							

			101	/pe or Print in B \$900 2/4/10 State of Maryland	/ Depa	irtment of r	realth and i	All Copie dental Hy	s Are Leg	gible.	000	
			State Registrar		Cer	tificate of L	Death		Reg. No.			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) SARA A. R	Sara R. Norw	itz			2. Date of De			of Death	
-	Examin		4a. Facility Name (if not institution, give stre 907 WHITEHALL STRE	ET		4b. City, Town, or SILVER SILVER	PRING If Under 24 Hrs.	8. Date of Bir	ТИОМ	ty of Death TGOMERY 9. Birthplace (State	or Foreign	
	Funeral Director		5. Social Security Number 218-03-1421 Usual Residence of Decedent	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	p1/26/1		Country) MD	- Controllegin	
	Maryland 28a-f shov otified at	Director	10a. State 10b. County MD MONTGOMER		Town or Loc ER SP					10d. Inside	City Limits es 2 🕅 No	
	ith the		10e. Street and Number 907 WHITEHALL STRE	FT		10f. Zip Code 20901		10g. Citizen o	, Citizen of What Country?			
36	s filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral		. Was Decedent Ever in U.S. Armed Forces (1) 1 Yes 2 No If Yes, give Year or Dates.		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:		ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - American Indian, ack, White, etc. fy: WHITE		
21215-0036	thin 72 hours sne. than "natur he Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ation	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of	Business Industry		
land 2		امها	17. Father's Name (First, Middle, Last) JOEL	FINE		_	18. Mother's Nam	ne (First, Middle, MARY		me) CAPLAN	_	
, Maryland	id 2 should be file salth and Mental I n 27 is marked c er traumatic eve		19a. Informant's Name/Relationship (Type, MARY BRENNER/DAUGH				and Number or Rur L STREET,				01	
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cen	netery, cren ISRA	sition (Name of natory or other place EL CONG.	2/3/		BALTIMO	-		
Balt	permit. Page Department of Important: If any injury or once.	_	21. Signature of Funeral Service Licensee		8	900 REIS	TERSTOWN	ROAD, F	PIKESVII	ROS., INC. LLE, MD 212	208	
index.	Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. cause on each line.			ng, such as cardiac			Approxin Interval E Onset an	Between	
	Medical Examiner	_	resulting in death)	Due to (or as a consequent	nce of):					y	VS	
	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	High: High: Due to (or as a conseque Due to (or as a conseque	nce of):	31		· · · · · · · · · · · · · · · · · · ·		4	<u>s</u>	
09/	ate be exe physician a the burial-		d.	Hyperlipid	dem	4				yv.	5	
Box 68760	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♠ No 9 ☐ Unknown	c. If yes, outcome of pregnand 1 Live Birth 2 Fetal of 4 Pregnant at time of de g Unknown	death 3	Ectopic pregnand Other (specify)	су			Date of delivery Month Day	Year
s, P.O.	ires that the des signed by the s d be detached		Part II. Other significant conditions cont	anemea B	, de	nderlying cause gi	iven in Part I.			ontribute to the cause on a Probably 4	45	
Records,	The law require ate has been si page 2 should		Sementia with m	nemory problem	o, Le	ev kome	G.			o. Were autopsy finding prior to completion of death? 1 Yes 2 No	gs available of cause of	
al B	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. P	lace of Death (Chec	_	2 140			
of Vital	Physician: this certific al director,	은	1 ☐ Yes 2 ♠ No	spital:			4 L Nursing H	ome 5 Res				
o u	r Attending F er death. rector: After i by the funera	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 Natural 5 Pending 2 Daccident Investigation 28b. Time of injury 1 Pending 2 Pending 1 Pe							uired			
Division	al or Attendii s after death. Il Director: Af ed in by the fu	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str					nd Number or Rural Route Number, e)		
_	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 Medical Examine	an: To the best of my knowled r: On the basis of examination of Practioner: To the best of my l	and/or inves	tigation, in my opini	ion, death occurred	at the time, date	and place, and one cause(s) and	due to the cause(s) and manner as stated.	manner stated	
	To the within 2 To the comple		29b. Signature and title of certifier	lly mo		29c. Licens	4749	?	Feb 29d. Date sign	ned (Month, Day, Year)	10	
			30. Name and address of person who con	no 801 TUI	Heres	e Are,	D-1, FR	EDERK	K, Md	21701		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	M .	barke						